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

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SERRANO). Without objection, 5-minute voting will continue.

There was no objection.

RECOGNIZING 20TH ANNIVERSARY OF THE ENDING OF THE COLD WAR

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and agreeing to the resolution. H. Res. 892.

The Clerk read the title of the resolution.

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

The question was taken.

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

RECORDED VOTE

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

A recorded vote was ordered.

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

(Roll No. 883)

AYES—431

Aberson

Abercrombie

Ackerman

Adler

Akin

Alexander

Altman

Arcuri

Austria

Baca

Bachmann

Bachus

Baier

Baldwin

Barrett (NC)

Barrow

Bartlett

Barton (TX)

Bean

Beccerra

Berkley

Blain

Bilirakis

Bishop (GA)

Bishop (NY)

Bishop (UT)

Blackburn

Blumauer

Blundon

Cummings

Dahlkemper

Davis (CA)

Davis (IL)

Davis (KY)

Deal (GA)

DeLauro

Dent

Diaz-Balart, L

Diaz-Balart, M

Dingell

Doggett

Donnelly (IN)

Doyle

Dreier

Driehaus

Duncan

Edwards (MD)

Ed office (TX)

Ehlers

Ellison

Elisworth

Emerson

Engel

Einsel

Eshoo

Etheridge

Fallin

Filner

Flake

Fleming

Fortenberry

Foster

Frank (MA)

Frank (AZ)

Garth...
Subtitle C—Individual Affordability Credits

TITLE IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Subtitle B—Employer Responsibility

TITLE V—INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

Subtitle B—Credit for Small Business Employers Health Coverage Expenses

Subtitle C—Disclosures To Carry Out Health Insurance Exchange Subsidies

Subtitle D—Other Revenue Provisions

DIVISION B—MEDICARE AND MEdICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions related to Medicare Part A

Subtitle B—Provisions Related to Part B

Subtitle C—Provisions Related to Medicare Parts A and B

Subtitle D—Medicare Advantage Reforms

Subtitle E—Improvements to Medicare Part D

Subtitle F—Medicare Rural Access Protections

TITLE II—MEDIcARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

Subtitle B—Reducing Medicare Health Disparities

Subtitle C—Miscellaneous Improvements

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

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Subtitle B—Nursing Home TransparencY

Subtitle C—Quality Measurements

Subtitle D—Physician Payments Sunshine Provision

Subtitle E—Public Reporting on Health Care-Associated Infections

TITLE V—MEdICARE GRADUATE MEDICAL EDUCATION

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased funding to fight waste, fraud, and abuse

Subtitle B—Enhanced penalties for fraud and abuse

Subtitle C—Enhanced Program and Provider Protections

Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse

TITLE VII—MEdICAID AND CHIP

Subtitle A—Medicaid and Health Reform

Subtitle B—Prevention

Subtitle C—Access

Subtitle D—Coverage

Subtitle E—Financing

Subtitle F—Waste, Fraud, and Abuse

Subtitle G—Puerto Rico and the Territories

Subtitle H—Miscellaneous

TITLE VIII—REVENUE-RELATED PROVISIONS

TITLE IX—MISCELLANEOUS PROVISIONS

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

TITLE I—COMMUNITY HEALTH CENTERS

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

Subtitle B—Nursing Workforce

Subtitle C—Public Health Workforce

Subtitle D—Adapting Workforce to Evolving Health System Needs

TITLE III—PREVENTION AND WELLNESS

Subtitle A—Community and Subsidy

Subtitle B—Other Provisions

Subtitle C—Drug Discount for Rural and Other Hospitals; 340B Program Interagency

Subtitle B—Programs

Subtitle C—Food and Drug Administration

Subtitle D—Community Living Assistance Services and Supports

Subtitle E—Miscellaneous

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

TITLE I—AMENDMENTS TO INDIAN LAWS

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

SECTION 100: PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.

(a) PURPOSE.

(1) IN GENERAL.—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today’s health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;

(C) includes sliding scale affordability credits; and

(D) initiates shared responsibility among workers, employers, and the Government; so that all Americans have coverage of essential health benefits.

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

(b) TABLE OF CONTENTS OF DIVISION.—The table of contents of this division is as follows:

Sec. 100. Purpose; table of contents of division; general definitions.

TITLE I—IMMEDIATE REFORMS

Sec. 101. National high-risk pool program.

Sec. 102. Ensuring value and lower premiums.

Sec. 103. Ending health insurance rescissions.

Sec. 104. Preventing preexisting condition exclusions.

Sec. 105. Requiring the option of extension of dependent coverage for uninsured young adults.

Sec. 106. Limitations on preexisting condition exclusions.

Sec. 107. Prohibiting acts of domestic violence from being treated as preexisting conditions.

Sec. 108. Ending health insurance denials and delays of necessary treatment for children with deformities.

Sec. 109. Elimination of lifetime limits.

Sec. 110. Prohibition against postretirement reductions of retiree health benefits by group health plans.

Sec. 111. Requirement of program for retirees.

Sec. 112. Wellness program grants.

Sec. 113. Extension of COBRA continuation coverage.

Sec. 114. State Health Access Program grants.

Sec. 115. Administrative simplification.

DIVISION II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFIT PLANS

Subtitle A—General Standards

Sec. 201. Requirements reforming health insurance marketplace.

Sec. 202. Protecting the choice to keep current coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 211. Prohibiting preexisting condition exclusions.

Sec. 212. Guaranteed issue and renewal for insured plans and prohibiting rescissions.

Sec. 213. Insurance rating rules.

Sec. 214. Non-discrimination in benefits; parity in mental health and substance abuse disorder benefits.

Sec. 215. Ensuring adequacy of provider networks.

Sec. 216. Requiring the option of dependent coverage for uninsured young adults.

Sec. 217. Consistency of costs and coverage under qualified health benefits plans during plan year.

Sec. 218. Standards Guaranteeing Access to Essential Benefits

Sec. 221. Coverage of essential benefits package.

Sec. 222. Essential benefits package defined.

Sec. 223. Health Benefits Advisory Committee.

Sec. 224. Process for adoption of recommendations; adoption of benefit standards.

Subtitle D—Additional Consumer Protections

Sec. 231. Requiring fair marketing practices by health insurers.

Sec. 232. Requiring fair grievance and appeals mechanisms.

Sec. 233. Requiring information transparency and plan disclosure.

Sec. 234. Application to qualified health benefits plans not offered through the Health Insurance Exchange.

Sec. 235. Timely payment of claims.

Sec. 236. Standardized rules for coordination and subrogation of benefits.

Sec. 237. Application of administrative simplification.

Sec. 238. State prohibitions on discrimination against health care providers.

Sec. 239. Protection of physician prescriber information.

Sec. 240. Dissemination of advance care planning information.


Sec. 242. Duties and authority of Commissioner.

Sec. 243. Consultation and coordination.

Sec. 244. Health Insurance Ombudsman.

Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 251. Relation to other requirements.

Sec. 252. Prohibiting discrimination in health care.

Sec. 253. Whistleblower protection.

Sec. 254. Construction regarding collective bargaining.

Sec. 255. Severability.

Sec. 256. Treatment of Hawaii Prepaid Health Care Act.

Sec. 257. Actions by State attorneys general.

Sec. 258. Application of State and Federal laws regarding abortion.

Sec. 259. Non-discrimination on abortion and respect for rights of conscience.


Sec. 261. Construction regarding standard of care.

Sec. 262. Restoring application of antitrust laws to health sector insurers.

Sec. 263. Study and report on methods to increase EHR use by small health care providers.
Sec. 264. Performance Assessment and Accountability; Application of GPRA

Sec. 301. Establishment of Health Insurance Exchange; outline of duties; definitions.

Sec. 302. Exchange-eligible individuals and employers.

Sec. 303. Benefits package levels.

Sec. 304. Contracts for the offering of Exchange-participating health benefits plans.

Sec. 305. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.

Sec. 306. Other functions.

Sec. 307. Health Insurance Exchange Trust Fund.

Sec. 308. Optional operation of State-based health insurance exchanges.

Sec. 309. Interstate health insurance compacts.

Sec. 310. Health insurance cooperatives.

Sec. 311. Retention of DOD and VA authority.

Subtitle B—Public Health Insurance Option

Sec. 321. Establishment and administration of a public health insurance option Exchange-qualified health benefits plan.

Sec. 322. Premiums and financing.

Sec. 323. Payment rates for items and services.

Sec. 324. Modernized payment initiatives and delivery system reform.

Sec. 325. Premiums participation.

Sec. 326. Application of fraud and abuse provisions.

Sec. 327. Application of HIPAA insurance requirements.

Sec. 328. Application of health information privacy, security, and electronic transaction requirements.

Sec. 329. Enrollment in public health insurance option is voluntary.

Sec. 330. Enrollment in public health insurance option by Members of Congress.

Sec. 331. Reimbursement of Secretary of Veterans Affairs.

Subtitle C—Individual Affordability Credits

Sec. 341. Availability through Health Insurance Exchange.

Sec. 342. Affordable credit eligible individual.

Sec. 343. Affordable credit premium credit.

Sec. 344. Affordability cost-sharing credit.

Sec. 345. Income determinations.

Sec. 346. Special rules for application to territories.

Sec. 347. No Federal payment for undocumented aliens.

Subtitle D—Individual Responsibility

Sec. 348. Health care participation requirements.

Sec. 349. Employer responsibility to contribute toward employee and dependent coverage.

Sec. 350. Employer contributions in lieu of coverage.

Sec. 351. Authority related to improper filing.

Sec. 352. Impact study on employer responsibility requirements.

Sec. 361. Study on employer hardship exemption.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS


Sec. 422. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986.

Sec. 423. Satisfaction of health coverage participation requirements under the Public Health Service Act.

Sec. 424. Additional rules relating to health coverage participation requirements.

TITILE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

SUBPART A—INDIVIDUAL RESPONSIBILITY

Sec. 501. Tax on individuals without acceptable health care coverage.

SUBPART B—EMPLOYER RESPONSIBILITY

Sec. 511. Election to satisfy health coverage participation requirements.

Sec. 512. Health care contributions of non-electing employers.

Sec. 521. Credit for small business employee health coverage expenses.

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

Sec. 531. Distributions for medicine qualified only if for prescribed drug or insulin.

Sec. 532. Limitation on health flexible spending arrangements under cafeteria plans.

Sec. 533. Increase in penalty for nonqualified distributions from health savings accounts.

Sec. 534. Denial of deduction for federal subsidies for prescription drug plans which have been excluded from gross income.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

Sec. 541. Disclosures to carry out health insurance exchange subsidies.

Sec. 542. Offering of exchange-participating health benefits plans through cafeteria plans.

Sec. 543. Exclusion from gross income of payments made under reinsurance program for retirees.

Sec. 544. CLASS program treated in same manner as long-term care insurance.

Sec. 545. Exclusion from gross income for medical care provided for Indians.

Sec. 546. Exchange-participating health benefits plans.

Sec. 551. Surcharge on high income individuals.

Sec. 552. Excise tax on medical devices.

Sec. 553. Expansion of information reporting requirements.

Sec. 554. Repeal of Worldwide Allocation of Interest.

Sec. 555. Exclusion of Unprocessed fuel from cellulosic biofuel producer credit.

PART 2—PREVENTION OF TAX AVOIDANCE

Sec. 561. Limitation on treaty benefits for certain deductible payments.

Sec. 562. Codification of economic substance doctrine; penalties.

Sec. 563. Certain large or publicly traded persons made subject to a more likely than not standard for avoiding penalties on underpayments.

PART 3—PARTY IN HEALTH BENEFITS

Sec. 571. Certain health related benefits applicable to employees' dependents extended to eligible beneficiaries.

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

(1) ACCEPTABLE COVERAGE.—The term “acceptable coverage” has the meaning given such term in section 363(d)(2).

(2) BASIC PLAN.—The term “basic plan” has the meaning given such term in section 303(c).

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

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

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

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

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

(B) includes such a plan that is the following:

(1) FEDERAL, STATE, AND TRIBAL GOVERNMENTAL PLANS.—A governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), including a health benefits plan offered under chapter 89 of title 5, United States Code;

(11) CHURCH PLANS.—A church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974); and

(7) ENHANCED PLAN.—The term “enhanced plan” has the meaning given such term in section 308(c).

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

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

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

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

(12) HEALTH BENEFITS PLAN.—The term “health benefits plan” means health insurance coverage and depends on health plan and includes the public health insurance option.

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

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

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

15. HEALTH INSURANCE EXCHANGE.—The term "Health Insurance Exchange" means the Health Insurance Exchange established under section 301.

16. INDIAN.—The term "Indian" has the meaning given such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

17. INDIAN HEALTH CARE PROVIDER.—The term "Indian health care provider" means a health care program operated by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization as such term is defined in section 101 of the Indian Health Care Improvement Act (25 U.S.C. 1601).

18. MEDICAID.—The term "Medicaid" means a State plan under section 1902 of such Act.

19. MEDICAID ELIGIBLE INDIVIDUAL.—The term "Medicaid eligible individual" means an individual who is eligible for medical assistance under Medicaid.

20. MEDICARE.—The term "Medicare" means the health programs under title XVIII of the Social Security Act.

21. PLAN.—The term "plan" means a health plan, a plan year as specified under section 2791(c)(1) of the Code, and premiums payable thereunder.

22. PLAN SPONSOR.—The term "plan sponsor" means—

(A) the employer; (B) an association of employers and 1 or more employee organizations; or (C) a plan maintained jointly by 1 or more employers.

23. PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms "premium plan" and "premium-plus plan" have the meanings given such terms in section 303(c).

24. QHP OFFERING ENTITY.—The terms "QHBP offering entity" mean the persons and groups that maintain and offer Qualified Health Benefits Plans.

25. QUALIFIED HEALTH BENEFITS PLAN.—The term "qualified health benefit plan" means such employer, group health plan, or the issuer of money or other financial consideration for dismembering the coverage.

26. PUBLIC HEALTH INSURANCE OPTION.—The term "public health insurance option" means the public health insurance option as provided under subtitle B of title III.

27. SERVICE AREA; PREMIUM RATING AREA.—The terms "service area" and "premium rating area" mean with respect to health insurance coverage—

(A) offered other than through the Health Insurance Exchange, such an area as established by the QHBP offering entity of such coverage in accordance with applicable State law; and

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

28. STATE.—The term "State" means the 50 States and the District of Columbia and includes—

(A) for purposes of title I, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; and

(B) for purposes of titles II and III, as elected under and subject to section 346, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

29. STATE MEDICAID AGENCY.—The term "State Medicaid agency" means, with respect to a Medicaid eligible individual, the single State agency responsible for administering such plan under title XIX of the Social Security Act.

30. VARIOUS OTHER DEFINITIONS.—The terms "Y1", "Y2", etc. are defined in section 301.

 TITLE I—IMMEDIATE REFORMS

SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a temporary national high-risk pool program (in this section referred to as the "program") to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and, subject to subsection (b)(3)(B), ending on the date on which the Health Insurance Exchange is established.

(b) ADMINISTRATION.—The Secretary may carry out this section directly or, pursuant to agreements, grants, or contracts with States, through risk pool programs provided that the requirements of this section are met. For a State without a high-risk pool program, the Secretary may work with the State to coordinate with other forms of coverage expansions, as State public-private partnerships.

(c) ELIGIBILITY.—For purposes of this section, the term "eligible individual" means an individual who meets the requirements of subsection (1)(B)

(1) who—

(A) is not eligible for—

(i) benefits under title XVIII, XIX, or XXI of the Social Security Act; or

(ii) coverage under an employment-based health plan; or

(iii) a plan maintained solely on account of age or coverage under an employment-based health plan that is—

(a) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, the plan sponsor’s group health plan, and "employee health benefit plan" means the health benefit plan of any employer, group health plan, or the issuer of money or other financial consideration for dismembering the coverage.

(b) who is the spouse or dependent of an individual who is described in paragraph (1);

(c) who has not had health insurance coverage or coverage under an employment-based health plan for at least the 6-month period immediately preceding the date of the individual’s application for high-risk pool coverage under this section; or

(d) who on or after October 29, 2009, had employment-based retiree health coverage (as defined in subsection (d) at any time during the 6-month period ending on the date the individual applies for high-risk pool coverage under this section and is not eligible for Medicare, and the individual was denied such coverage because of a preexisting condition; or

(e) who was offered such coverage—

(i) under terms that the coverage would be considered to be for a preexisting condition; or

(ii) at a premium rate that is above the premium rate for high risk pool coverage under this section; or

(f) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual coverage at the rate specified in such paragraph, the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rates for attributable to differences in age rating.

(e) ENROLLMENT.—To enroll in coverage in the program, an individual shall—

(1) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require to determine eligibility.

(2) attest, consistent with subsection (b)(3), that the individual is an eligible individual and is a resident of one of the 50 States or the District of Columbia; and

(f) PROTECTION AGAINST DUMPING RISKS BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans or any combination thereof have encouraged the disenrollment of eligible individuals.

(2) SANCTIONS.—If the Secretary finds that any employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from such health plan.

(3) If the individual had other prior health insurance coverage or coverage under an employment-based health plan during the preexisting condition period, as defined by the Secretary, the Secretary may make adjustments to offset differences in premium rates for attributable to differences in age rating.

(2) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual coverage at the rate specified in such paragraph, the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rates for attributable to differences in age rating.

(e) ENROLLMENT.—To enroll in coverage in the program, an individual shall—

(1) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require to determine eligibility.

(2) attest, consistent with subsection (b)(3), that the individual is an eligible individual and is a resident of one of the 50 States or the District of Columbia; and

(f) PROTECTION AGAINST DUMPING RISKS BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans or any combination thereof have encouraged the disenrollment of eligible individuals.

(2) SANCTIONS.—If the Secretary finds that any employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from such health plan.

(3) If the individual had other prior health insurance coverage or coverage under an employment-based health plan during the preexisting condition period, as defined by the Secretary, the Secretary may make adjustments to offset differences in premium rates for attributable to differences in age rating.

(2) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual coverage at the rate specified in such paragraph, the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rates for attributable to differences in age rating.
(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or
(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage) and the prior coverage is a policy that no longer being actively marketed (as defined by the Secretary) by the issuer; or
(ii) the prior coverage is a policy for which durational limitations on issue or health status factors are that can be considered in determining premiums at renewal.

(3) Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing the Secretary from enjoining such paragraph or other provisions under law with respect to health insurance issuers.

(g) COVERED BENEFITS, COST-SHARING, PREMIUMS, AND CONSUMER PROTECTIONS.—

(1) PREMIUM.—The monthly premium charged to eligible individuals for coverage under the program:
(A) may vary by age so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1; (B) shall be a premium that does not exceed 125 percent of the prevailing standard rate for comparable coverage in the individual market; and
(C) shall be adjusted for geographic variation in costs.

Health insurance issuers shall provide such information as the Secretary may require to determine prevailing standard rates under this paragraph. The Secretary shall establish standard rates in consultation with the National Association of Insurance Commissioners.

(2) COVERED BENEFITS.—Covered benefits under the program shall be determined by the Secretary and shall be consistent with the basic categories in the essential benefits package described in section 222. Under such benefits package—
(A) the annual deductible for such benefits may not be higher than $1,500 for an individual or such higher amount for a family as determined by the Secretary;
(B) there may not be annual or lifetime limits; and
(C) the maximum cost-sharing with respect to an individual (or family) for a year shall not exceed $5,000 for an individual (or $10,000 for a family).

(3) NO PREEXISTING CONDITION EXCLUSION PERIODS.—No preexisting condition exclusion period shall be imposed on coverage under the program.

(4) APPEALS.—The Secretary shall establish an appeals process for individuals to appeal a determination of the Secretary—
(A) with respect to claims submitted under this section; and
(B) with respect to eligibility determinations made by the Secretary under this section.

(5) STATE CONTRIBUTION, MAINTENANCE OF EFFORT.—As a condition of providing health benefits under this section, eligible individual residing in a State—
(A) in the case of a State in which a qualified high-risk pool (as defined under section 274c of the Public Health Service Act) was in effect as of July 1, 2009, the Secretary shall require the State make a maintenance of effort payment each year that the high-risk pool is in effect to an amount not less than the amount of all sources of funding for high-risk pool coverage made by that State in the year ending July 1, 2009; and
(B) the Secretary may require health insurance issuers to contribute to a State high-risk pool or similar arrangement for the assessment against such issuers for pool losses, the State shall maintain such a contribution arrangement among such issuers.

(b) LIMITING PROGRAM EXPENDITURES.—The Secretary shall, with respect to the program—
(A) establish procedures to protect against fraud, waste, and abuse under the program; and
(B) provide for other program integrity methodologies.

(c) TREATMENT AS CREDIBLE COVERAGE.—Coverage under the program shall be treated, for purposes of applying the definition of 'credible coverage' under the provisions of title XXVII of the Public Health Service Act, part 6 of subtitle B of title I of Employee Retirement Income Security Act of 1974, and chapter 100 of the Internal Revenue Code of 1986 (and any other provision of law that references such provisions) in the same manner as if it were coverage under a State health benefits risk pool described in section 2701(c)(1)(G) of the Public Health Service Act.

(d) FUNDING; TERMINATION OF AUTHORITY.—

(1) IN GENERAL.—There is appropriated to the Secretary to cover the expenses of the high-risk pool in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and administrative costs of) the high-risk pool under this section in excess of the premiums collected with respect to eligible individuals enrolled in the high-risk pool. Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for payment of expenses of the high-risk pool will be less than the amount of the expenses, the Secretary shall make such adjustments as are necessary to ensure that any reducing benefits, increasing premiums, or establishing waiting lists.

(3) TERMINATION OF AUTHORITY.—

(A) IN GENERAL.—As provided in subparagraph (B), coverage of eligible individuals under a high-risk pool shall terminate as of the date on which the Health Insurance Exchange is established.

(B) TRANSITION TO EXCHANGE.—The Secretary shall develop procedures to provide for the transition of eligible individuals who are enrolled in coverage offered through a high-risk pool established under this section to be enrolled in acceptable coverage. Such procedures shall ensure that there is no gap in coverage with respect to the individual and may extend coverage offered through such a high-risk pool beyond 2012 if the Secretary determines necessary to avoid such a lapse.

(i) APPLICATION AND VERIFICATION OF REQUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE IN THE UNITED STATES.

(1) REQUIREMENT.—No individual shall be an eligible individual under this section unless the individual is a citizen or national of the United States, as defined in section 101(a)(30) of title 8, or an alien lawfully present in the United States (other than as a nonimmigrant described in a subparagraph (K), (T), (U), and (V) of section 101(a)(15) of the Immigration and Nationality Act.)

(2) VERIFICATION PROCESS FOR APPLICANTS.—The provisions of paragraphs (4) (other than subparagraphs (F) and (H)(1)) and (5)(A) of section 341(b), and of subsections (v) (other than paragraph (3) of section 2701(c)(1)(U) of the Internal Revenue Code, shall apply to the verification of eligibility of an individual by the Secretary (or by a State agency approved by the Secretary) under this section, in the same manner as such provisions apply to the verification of eligibility of an affordable credit eligible individual for affordability credits by the Commissioner under section 341(b). The agreement referred to in section 3101(c)(2)(A) of the Social Security Act, as applied under this paragraph, shall also provide for funding, to be payable for the amount made available under subsection (h)(1), to the Commissioner of Social Security in such amount as is required to fund such Commissioner and the Secretary.

(j) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—In this section, the term ‘employment-based retiree health coverage’ means health insurance or other coverage of health care costs (whether provided by voluntary insurance or pursuant to statutory or contractual obligation) for individuals (or such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

SEC. 102. ENSURING VALUE AND LOWER PREMIUMS.

(a) GROUP HEALTH INSURANCE COVERAGE.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.

“(a) IN GENERAL.—Each health insurance issuer that offers health insurance coverage in the small or large group market shall provide that for any plan year in which the coverage has a medical loss ratio below a level specified by the Secretary (but not less than 85 percent), the issuer shall offer in a manner specified by the Secretary for rebates to enrollees of the amount by which the issuer’s medical loss ratio is less than the level so specified.

“(b) IMPLEMENTATION.—The Secretary shall establish a uniform definition of medical loss ratio and methodology for determining how to compute it based on the medical loss ratio in a health insurance issuer’s book of business for the small and large group market. Such methodology shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. In determining the medical loss ratio, the Secretary shall exclude State taxes and licensing or regulatory fees. Such methodology shall be designed and exceptions shall be established to ensure adequate participation in the health insurance market, competition in the health insurance market, and value for consumers so that their premiums are used for services.

(c) SUBSECTIONS (A), (B), AND (C) SHALL NOT APPLY TO HEALTH INSURANCE COVERAGE AND ON AND AFTER THE FIRST DATE THAT HEALTH INSURANCE COVERAGE IS OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Such title is further amended by inserting after section 2753 the following new subsection:

SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

“The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the same manner as such provisions apply to health insurance coverage offered under this section, except to the extent the Secretary determines that the application of such section may destabilize the existing individual market.

(c) IMMEDIATE IMPLEMENTATION.—The amendments made by this section shall apply in the group and individual market for years beginning on or after January 1, 2010, or as soon as practicable after such date.

SEC. 103. ENDING HEALTH INSURANCE RESCISIONS.

(a) CLARIFICATION REGARDING APPLICATION OF GUARANTEED RENEWABILITY OF INDIVIDUAL
AND GROUP HEALTH INSURANCE COVERAGE.—Sections 2712 and 2742 of the Public Health Service Act (42 U.S.C. 300gg-12, 300gg-42) are each amended—

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION;", after "GUARANTEED RENEWABILITY;" and

2) by inserting, by adding and inserting—"and

2) by inserting, by adding and inserting—"and

(b) SECRETARIAL GUIDANCE REGARDING RESCISSIONS.—

(b) SECRETARIAL GUIDANCE REGARDING RESCISSIONS.—

(1) GROUP HEALTH INSURANCE MARKET.—

(1) GROUP HEALTH INSURANCE MARKET.—

Section 2712 of such Act (42 U.S.C. 300gg-12) is amended by adding at the end the following:

"(f) Rescission.—A health insurance issuer may rescind individual health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.

"(g) Exemption for initial one-year enrollment.—In making determinations concerning entering into contracts with QHPs for the offering of Exchange-participating health plans under section 304, the Commissioner shall take into account the information and recommendations provided under paragraph (1).

(2) MONITORING BY COMMISSIONER OF PREMIUM INCREASES.—

(2) MONITORING BY COMMISSIONER OF PREMIUM INCREASES.—

(A) IN GENERAL.—In determining under section 332(c)(4) whether to make additional larger employers eligible to participate in the Health Insurance Exchange, the Commissioner shall take into account the experience gained in extending growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by States.

(B) COMMISSIONER AUTHORITY REGARDING EXCHANGE PARTICIPATION.—In making determinations concerning entering into contracts with QHPs for the offering of Exchange-participating health plans under section 304, the Commissioner shall take into account the information and recommendations provided under paragraph (1).

(3) PREMIUM INCREASES.—

(3) PREMIUM INCREASES.—

(A) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that year or dependent children shall make available such coverage, at the option of the participant in- 

(B) CONSIDERATION IN OPENING EXCHANGE.—

(B) CONSIDERATION IN OPENING EXCHANGE.—

In determining under section 322(c)(4) whether to make additional larger employers eligible to participate in the Health Insurance Exchange, the Commissioner shall take into account the experience gained in extending growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by States.

(c) GRANTS IN SUPPORT OF PROCESS.—

(c) GRANTS IN SUPPORT OF PROCESS.—

(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program of grants to States during the 5-year period beginning with 2010 to assist them in carrying out subsection (a), including—

(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third-party of a rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be rescinded under the guidance issued by the Secretary under section 2742(f).

(2) APPLICATION TO GROUP HEALTH INSURANCE.—Such title is further amended by adding after section 2702 the following new section:

"SEC. 2703. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

(a) INITIAL PREMIUM REVIEW PROCESS.—

(a) INITIAL PREMIUM REVIEW PROCESS.—

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to indi-

1) by inserting, by adding and inserting—"AND CONTINUATION IN FORC—'

2) by inserting, by adding and inserting—"and

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.
from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.

(3) IRC.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

**SEC. 9804. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.**

(a) IN GENERAL.—A group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b) of the participant)—

(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan—

'qualified child' including—

(1) is under 27 years of age;

(2) is a participant, beneficiary, or enrollee (other than under this section, section 704 of the Employee Retirement Income Security Act of 1974, or section 2704 or 2746 of the Public Health Service Act) under any health insurance plan or group health plan.

(c) PREMIUMS NOTHING in this section shall be construed as preventing a group health plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.'.

(b) CLERICAL AMENDMENT.—The table of sections of this chapter is amended by inserting after the item relating to section 9803 the following:

**Sec. 9804. Requiring the option of extension of dependent coverage for uninsured young adults.**

**Sec. 2746. Requiring the option of extension of dependent coverage for uninsured young adults.**

The provisions of section 2703 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—The amendments made by subsection (a) shall apply to group health plans for plan years beginning on or after January 1, 2010.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2746 of the Public Health Service Act (42 U.S.C. 300gg(d)(3)) is amended by adding at the end the following new section:

**Sec. 2746. Requiring the option of extension of dependent coverage for uninsured young adults.**

The provisions of section 2703 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—The amendments made by subsection (a) shall apply to group health plans for plan years beginning on or after January 1, 2010.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2746 of the Public Health Service Act (42 U.S.C. 300gg(d)(3)) is amended by adding at the end the following new section:

**Sec. 106. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS IN GROUP HEALTH PLANS IN ADVANCE OF APPLICABILITY OF NEW PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.**

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking "6-month period" and inserting "12-month period".

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 701(a)(2) of such Act (29 U.S.C. 1181(a)(2)) is amended by striking "3 months" and inserting "9 months".

(3) SUNSET OF INTERIM LIMITATION.—Section 701 of such Act is amended by adding at the end the following new subsection:

"(b) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions)."

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 9801(a)(1) of the Internal Revenue Code of 1986 is amended by striking "6-month period" and inserting "30-day period".

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 9801(a)(2) of such Code is amended by striking "12 months" and inserting "3 months", and by striking "18 months" and inserting "9 months".

(3) SUNSET OF INTERIM LIMITATION.—Section 9801 of such Code is amended by adding at the end the following new subsection:

"(b) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions)."

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)) is amended by striking "6-month period" and inserting "30-day period".

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 2701(a)(2) of such Act (42 U.S.C. 300gg(a)(2)) is amended by striking "12 months" and inserting "3 months", and by striking "18 months" and inserting "9 months".

(3) SUNSET OF INTERIM LIMITATION.—Section 2701 of such Act (42 U.S.C. 300gg) is amended by adding at the end the following new subsection:

"(b) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions)."

(d) MISCELLANEOUS TECHNICAL AMENDMENT.—Section 2702(a) of such Act (42 U.S.C. 300gg-1) is amended by striking "701" and inserting "701 and 9801.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the provisions of this section shall apply to respect to group health plans for plan years beginning on or after April 1, 2010.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date that such plan terminates;

(B) the date that such plan terminates;

(C) the date that such plan terminates;

(D) the date that such plan terminates;

(E) the date that such plan terminates;

(F) the date that such plan terminates;

(G) the date that such plan terminates;

(H) the date that such plan terminates;

(I) the date that such plan terminates;

(J) the date that such plan terminates;

(K) the date that such plan terminates;

(L) the date that such plan terminates;

(M) the date that such plan terminates;

(N) the date that such plan terminates;

(O) the date that such plan terminates;

(P) the date that such plan terminates;

(Q) the date that such plan terminates;

(R) the date that such plan terminates;

(S) the date that such plan terminates;

(T) the date that such plan terminates;

(U) the date that such plan terminates;

(V) the date that such plan terminates;

(W) the date that such plan terminates;

(X) the date that such plan terminates;

(Y) the date that such plan terminates;

(Z) the date that such plan terminates;
“(i) procedures that do not materially affect the function of the body part being treated; and
(ii) procedures for secondary conditions and follow-up treatment.

(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code is amended by adding at the end the following new item:

“Sec. 9104. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.”

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—

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

“SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

“(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—A group health plan that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

“(b) TREATMENT DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘treatment’ includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

“(A) procedures that do not materially affect the function of the body part being treated; and

“(B) procedures for secondary conditions and follow-up treatment.

“(2) CLERICAL AMENDMENT.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

“(B) EXCEPTION.—In this section, the term ‘treatment’ includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

“(1) procedures for secondary conditions and follow-up treatment.

“(2) CLERICAL AMENDMENT.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

“Sec. 9104. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.”

SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to health insurance coverage, or other coverage unit on a lifetime basis.

“(b) DEFINITION.—In this section, the term ‘aggregate dollar lifetime limit’ means, with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage in connection with an individual or other coverage unit on a lifetime basis.

“(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

“(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) as amended by section 108(c)(1), is amended by adding at the end the following:

“SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to health insurance coverage, or other coverage unit on a lifetime basis.

“(b) DEFINITION.—In this section, the term ‘aggregate dollar lifetime limit’ means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.

“(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

“SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

“The provisions of section 2709 shall apply to health insurance coverage offered by a health insurance issuer in the individual
market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(d) EFFECTIVE DATES.—
(1) The amendments made by this section shall apply to plans without regard to the date that the plan was in effect before June 30, 1989, and to plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) The amendment made by subsection (c)(2) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after such date.

SEC. 110. PROHIBITION AGAINST POSTRETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

(a) In general.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by sections 108 and 109, is amended by inserting after section 716 the following new section:

‘‘SEC. 717. PROTECTION AGAINST POSTRETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

‘‘(a) In general.—Every group health plan shall be prohibited from applying any adjustment, bar, or any limitation on the benefits provided under the plan to a retired participant, or beneficiary, as of the date the participant retired or the participant's beneficiary under the terms of the plan if such reduction occurs after the date the participant retired unless such reduction is also made with respect to active participants.

‘‘(b) No reduction.—Notwithstanding that a group health plan may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or the participant’s beneficiary unless such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the date the participant retired unless such reduction is also made with respect to active participants.

Nothing in this section shall prohibit any group plan from enforcing a total aggregate cap on amounts paid for retiree health coverage that is part of the plan at the time of retirement.

‘‘(b) No Reduction.—Notwithstanding that a group health plan may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or the participant’s beneficiary unless such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the date the participant retired unless such reduction is also made with respect to active participants.

(c) Reduction described.—For purposes of this section, a reduction in benefits—
(1) with respect to premiums occurs under a group health plan when a participant’s (or beneficiary’s) share of the total premium for the plan (in the case of a self-insured plan, the costs of coverage) of the plan substantially increases; or
(2) with respect to other cost-sharing and benefits under a group health plan occurs when there is a substantial decrease in the actuarial value of the benefit package under the plan.

For purposes of this section, the term ‘‘actuarial value’’ means an increase in the total premium share or a decrease in the actuarial value of the benefit package that is greater than 5 percent.

(d) Conforming amendment.—The table of contents of this Act, as amended by sections 108 and 109, is amended by inserting after the item relating to section 716 the following new item:

‘‘Sec. 717. Protection against postretirement reduction of retiree health benefits.’’

(c) Waiver.—An employer may, in a form and manner which shall be prescribed by the Secretary of Labor, apply for a waiver from this provision if the employer can reasonably demonstrate that meeting the requirements of this section would impose an undue hardship on the employer.

(d) Effective date.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 111. REINSURANCE PROGRAM FOR RETIREE HEALTH BENEFITS.

(a) Establishment.—
(1) In general.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall establish a reinsurance program to provide reinsurance to employers and employee associations (or employers or employee associations maintaining a single-employer plan) to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

(2) Definitions.—For purposes of this section:
(A) The term ‘‘eligible employment-based plan’’ means an employment-based plan that is participating in the reinsurance program.
(B) The term ‘‘Secretary’’ means Secretary of Health and Human Services.
(C) The term ‘‘employee association’’ means an eligible employment association or an eligible employee association maintaining a single-employer plan (as defined in section 305(f)(2) of the Internal Revenue Code of 1986). (D) The term ‘‘eligible employment-based plan’’ means—
(i) a single-employer plan (as defined in section 3(30) of the Employee Retirement Income Security Act of 1974); and
(ii) a multiple-employer plan (as defined in section 1102 of the Employee Retirement Income Security Act of 1974).

(3) Reimbursement.—The Secretary shall reimburse such plan for 80 percent of the costs attributable to such plan that exceed $15,000, but is less than $90,000. Such amounts shall be adjusted each year based on the percentage increase in the medical care component of the Consumer Price Index (rounded to the nearest multiple of $1,000) for the year involved.

(4) Appeals and program protections.—The Secretary shall establish—
(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and
(B) procedures to protect against fraud, waste, and abuse under this section.

(5) Audits.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that they are in compliance with the requirements of this section.

(d) Retiree Reserve Trust Fund.—
(1) Establishment.—
(A) In general.—There is established in the Treasury of the United States a trust fund to be known as the ‘‘Retiree Reserve Trust Fund’’ (referred to in this section as the ‘‘Trust Fund’’). Amounts as may be appropriated or credited to the Trust Fund as provided for in this subsection shall not be used as general revenues by the employer or employee association maintaining the plan, and reducing premium contributions, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries. Where the benefits are provided by an employer to members of a represented bargaining unit, the allocation of payments among these purposes shall be subject to collective bargaining. Amounts paid to the plan under this subsection shall not be used as general revenues by the employer or employee association maintaining the plan, and reducing premium contributions, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

(B) Funding.—There are hereby appropriated to the Trust Fund, out of any monies in the Treasury not otherwise appropriated, an amount requested by the Secretary as necessary to carry out this section, except that the total of all such amounts requested shall not exceed $75,000,000.

(C) Appropriations from the trust fund.—
(i) In general.—Amounts in the Trust Fund that are appropriated to participate in funding the reinsurance program shall be used to carry out such program.
SEC. 112. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

(1) IN GENERAL.—For purposes of this section, the Secretaries of Health and Human Services and Labor shall jointly award wellness program grants under this section.

Wellness program grants shall be awarded to small employers (as defined by the Secretary) for any plan year in an amount equal to 50 percent of the costs paid or incurred by such employers in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(b) LIMITATION.

(A) PRIORITY.—A wellness grant awarded to an employer under this section shall be for up to 3 years.

(B) AMOUNT.—The amount of the grant under paragraph (1) for an employer shall not exceed—

(i) the product of $150 and the number of employees of the employer for any plan year; and

(ii) $50,000 for the entire period of the grant.

(c) QUALIFIED WELLNESS PROGRAM.—For purposes of this section:

(1) IN GENERAL.—The term "qualified wellness program" means a program that—

(A) includes any 3 wellness components described in subsection (c); and

(B) is to be certified jointly by the Secretary of Health and Human Services and the Secretary of Labor, in coordination with the Director of the Centers for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

(i) is consistent with evidence-based research and best practices, as identified by persons with expertise in employer health promotion and wellness programs;

(ii) includes multiple, evidence-based strategies which are based on the existing and emerging research and careful scientific reviews, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs, and

(iii) includes strategies which focus on prevention and support for employee population health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies, shall jointly update such guidelines and procedures for periodic review, evaluation, and update of the programs under this subsection.

(3) HEALTH LITERACY AND ACCESSIBILITY.—The Secretaries of Health and Human Services and Labor shall jointly, as part of the certification process—

(A) ensure that employers make the program available to all employees, in a format and manner that is understandable and accessible (including for individuals with disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with literacy skills, limited English and from underserved populations;

and

(C) require the Secretaries to compile and disseminate examples of wellness programs information on model health literacy curricula, instructional programs, and effective intervention strategies.

(4) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow-up measures.

(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for the engagement of employees in worksite wellness programs through worksite assessments and program planning, onsite delivery, evaluation, and improvement efforts.

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which encourages healthy living through counseling, seminars, on-line programs, self-help manuals, or other programs which provide technical assistance and problem solving skills. Such component may include programs relating to—

(A) tobacco use; 

(B) obesity; 

(C) stress management; 

(D) physical fitness; 

(E) nutrition; 

(F) substance abuse; 

(G) depression; and 

(H) mental health promotion.

(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

(A) On-site delivery—Policies and services at the worksite which promote a healthy lifestyle, including policies relating to—

(i) tobacco use at the worksite; 

(ii) the availability of food available at the worksite through cafeterias and vending options; 

(iii) minimizing stress and promoting positive mental health; and

(iv) the encouragement of physical activity before, during, and after work hours.

(B) PARTICIPATION REQUIREMENT.—No grant shall be awarded under subsection (a) unless the Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies, certify, as a part of any award made under this subsection, that each wellness program component of the qualified wellness program—

(1) shall be available to all employees of the employer;

(2) shall not mandate participation by employees; and

(3) may provide a financial reward for participation of an individual in such program so long as such reward is not tied to the premium or cost-sharing of the individual under the health benefits plan.

(e) PROTECTIONS.—Data gathered for purposes of the employer wellness program may be used solely for the purposes of administering the program. The Secretaries of Health and Human Services and Labor shall develop standards to ensure that such data remain confidential and are not used for purposes beyond those for administering the program.

(f) CERTAIN COSTS NOT INCLUDED.—For purposes of this section, costs paid or incurred by an employer for providing protection under a COBRA continuation coverage plan shall not be taken into account under subsection (a).

(c) OUTREACH.—The Secretaries of Health and Human Services and Labor, in conjunction with other appropriate agencies and members of the business community, shall institute an outreach effort to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs acceptable to certain participating practices and on how to measure the success of implemented programs.

(d) EFFECTIVE DATE.—This section shall take effect on July 1, 2010.

SEC. 113. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) IN GENERAL.—In the case of any individual who is, under a COBRA continuation coverage provision, entitled to COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated as of the date of the enactment of this Act shall be increased by the number of months specified in subsection (b), extend to the earlier of the date on which such individual becomes eligible for acceptable coverage or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

(2) NOTICE.—As soon as practicable after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretaries of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide COBRA continuation coverage, provide rules setting forth the form and manner in which prompt notice to individuals of the continued availability of COBRA continuation coverage to such individuals under paragraph (1).

(b) CONTINUED EFFECT OF OTHER TERMINATING EVENTS.—Notwithstanding subsection (a), any required period of COBRA continuation coverage which is extended under such subsection shall terminate upon the occurrence, prior to the date of termination otherwise specified in subsection (a), of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of a specified number of months.

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provision of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired.

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

(1) COBRA CONTINUATION COVERAGE.—The term "COBRA continuation coverage"
means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 608), title XXIII of the Social Security Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1)) of such section insofar as it relates to pediatric vaccines, sections of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health care coverage for the uninsured populations in that State in a manner consistent with reforms to take effect under this division in Y1.

SEC. 114. STATE HEALTH ACCESS PROGRAM GRANTS.

(a) In general.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall provide grants to States (as defined for purposes of title XIX of the Social Security Act) to establish programs to expand access to affordable health care coverage for the uninsured populations in that State in a manner consistent with reforms to take effect under this division in Y1.

(b) Types of programs.—The types of programs for which grants are available under subsection (a) include the following:

(1) Implementation of key statutory or regulatory changes.—In order to be awardable under this section, a State shall demonstrate that:

(A) it has achieved the key State and local statutory or regulatory changes required to begin implementing the new program within 1 year after the initiation of funding under the grant; and

(B) it will be able to sustain the program without Federal funding after the end of the period of the grant.

(2) Ineligibility.—A State that has already developed a comprehensive health insurance access program is not eligible for a grant under this section unless the State has approved by the Secretary such an application in the form and manner as the Secretary specifies.

(3) Application required.—No State shall receive a grant under this section unless the State has approved by the Secretary such an application in the form and manner as the Secretary specifies.

(4) Administration based on current program.—The program under this section is administered by the State Health Access Program funded under the Omnibus Appropriations Act, 2009 (Public Law 111-8).

(d) Funding limitations.—

(1) In general.—A grant under this section shall—

(A) only be available for expenditures before Y1; and

(B) only be used to supplement, and not supplant, funds otherwise provided.

(2) Matching fund requirement.—

(A) In general.—No grant made under subparagraph (B), no grant may be awarded to a State unless the State demonstrates the seriousness of its effort by matching at least 20 percent of the amount, through non-Federal resources, which may be a combination of State, local, private dollars from insurers, providers, and other private organizations.

(B) Waiver.—The requirement of subparagraph (A) if the State demonstrates to the Secretary financial hardship in complying with such requirement.

(e) Study.—The Secretary shall review, study, and benchmark the progress and results of the programs funded under this section.

(f) Report.—Each State receiving a grant under this section shall submit to the Secretary a report on best practices and lessons learned through implementation and the results of the programs funded under this section beginning in Y1.

(g) Funding There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 115. ADMINISTRATIVE SIMPLIFICATION.

(a) Standardizing electronic administrative transactions.

(1) In general.—Part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) is amended by inserting after section 1173 the following:

"SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

(a) Standards for financial and administrative transactions.—

(1) In general.—The Secretary shall adopt and regularly update standards consistent with the goals described in paragraph (2).

"(2) Goals for financial and administrative transactions.—The goals for standards under paragraph (1) are that such standards shall:

(A) be unique with no conflicting or redundant standards;

(B) be authoritative, permitting no additions or exceptions on transactions, including companion guides;

(C) be comprehensive, efficient and robust, requiring minimal augmentation by payers and providers in the implementation of such standards;

(D) enable the real-time (or near real-time) determination of an individual’s financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician or health care provider, with special consideration given to such providers serving rural or underserved areas and ensure coordination with standards, implementation specifications, and certification criteria being adopted under the HIT/TECH Act;

(E) enable, where feasible, near real-time adjudication of claims;

(F) provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction deemed appropriate by the Secretary;

(G) describe all data elements (such as reason and remark codes) in unambiguous terms and in additional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions except where required by the (grant) State or Federal law or to protect against fraud and abuse; and

(H) harmonize all common data elements across administrative and clinical transaction standards.

(3) Time for adoption.—Not later than 2 years after the date of enactment of this section, the Secretary shall adopt standards under this section by interim, final rule.

(4) Requirements for specific standard adoption.—Under this section shall be developed, adopted, and enforced so as to—

(A) clarify, refine, complete, and expand, as needed, the standards required under section 1173;

(B) require paper versions of standardized transactions to comply with the same standards as their electronic transactions;\n
(C) require that all health plans and clearinghouses are able to process standard contracts without electronic transactions provided for in this part; and

(D) require timely and transparent claim and denial management processes, including uniform claim edits, uniform reason and remark codes, tracking, adjudication, and appeal processing.

(5) Building on existing standards.—In adopting the standards under this section, the Secretary shall consider existing and planned standards.

(6) Implementation and enforcement.—Not later than 6 months after the date of the enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

(A) a process and timeframe with milestones for developing the complete set of standards;

(B) a proposal for accommodating necessary changes between existing and new standards, including a process for upgrading standards as often as annually by interim, final rulemaking;

(C) programs to provide incentives for, and reduce the burden of, health care providers who volunteer to participate in the process of setting standards for electronic transactions;

(D) an estimate of total funds needed to ensure timely completion of the implementation plan; and

(E) an enforcement process that includes timely investigation of complaints, random audits to ensure compliance, civil monetary penalties for noncompliance consistent with existing laws and regulations, and a fair and reasonable appeals process building off of enforcement provisions under this part, and concurrent State enforcement jurisdiction.

(7) Report.—Not later than 3 years after the date of the enactment of this section, the Secretary shall submit to the Committees on Appropriations a report on the implementation of this section.

(b) Electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice;

(c) Require timely and transparent claim and denial management processes, including uniform claim edits, uniform reason and remark codes, tracking, adjudication, and appeal processing.

(3) Building on existing standards.—In adopting the standards under this section, the Secretary shall consider existing and planned standards.

(4) Implementation and enforcement.—Not later than 6 months after the date of the enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

(A) a process and timeframe with milestones for developing the complete set of standards;

(B) a proposal for accommodating necessary changes between existing and new standards, including a process for upgrading standards as often as annually by interim, final rulemaking;

(C) programs to provide incentives for, and reduce the burden of, health care providers who volunteer to participate in the process of setting standards for electronic transactions;

(D) an estimate of total funds needed to ensure timely completion of the implementation plan; and

(E) an enforcement process that includes timely investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for noncompliance consistent with existing laws and regulations, and a fair and reasonable appeals process building off of enforcement provisions under this part, and concurrent State enforcement jurisdiction.

(F) Enable, where feasible, near real-time adjudication of claims;
both syntactically and functionally compli-
ant with all the standard transactions man-
dated pursuant to the administrative sim-
plifications provided for in this part of the
Health Insurance Portability and Account-
ability Act of 1996.

(b) LIMITATIONS ON USE OF DATA.—Noth-
ing in this section shall be construed to per-
mit the use of information collected under
this section in a manner that would violate
State or Federal law.

(c) PROTECTION OF DATA.—The Secretary
shall ensure (through the promulgation of
regulations or otherwise) that all data col-
dected pursuant to subsection (a) are used
and disclosed only for purposes that meet the
HIPAA privacy and security law (as defined in
section 300.12(a)(2) of the Public Health
Service Act) and the applicable privacy or se-
curity standard adopted under section 3004 of
such Act.

SEC. 1173B. INTERIM COMPANION GUIDES, IN-
CLUDING OPERATING RULES.

(a) In General.—The Secretary shall
adopt a single, binding, comprehensive com-
panion guide, that includes operating rules
for open X12 Version 5010 transaction de-
scribed in section 1173(a)(2), to be effective
immediately upon completion of that guide.

(b) COMPANION GUIDE AND OPERATING
RULES DEVELOPMENT.—In adopting such in-
terim companion guide and rules, the Sec-
retary shall comply with section 1172, except
that a nonprofit entity that meets the fol-
lowing criteria shall also be consulted:

(1) The entity has in place a process of
administrative simplification.

(2) The entity uses a multistakeholder
process to create consensus-based com-
panion guides, including operating rules
using a voting process that ensures balanced
representation by the critical stakeholders
(including health plans and health care pro-
viders) so that no one group dominates the
entity and shall include others such as
standards development organizations, and
relevant Federal or State agencies.

(3) The entity has in place a public set of
guiding principles that ensure the compa-
nier guide and operating rules and process
are open and transparent.

(4) The entity coordinates its activities
with the HIT Policy Committee, and the HIT
Standards Committee (established under title
II of the Health Insurance Portability
Service Act) and complements the efforts of the
Office of the National Coordinator and its
related health information exchange goals.

(5) The entity incorporates the standards
issued under Health Insurance Portability
and Accountability Act of 1996 and this
part, and in developing the companion guide
and operating rules, does not change the defi-
nition, data condition or use of a data ele-
ment or segment in a standard, add any ele-
ments or segments to the maximum defined data
set, use any codes or data elements that are
either marked ‘‘not used’’ in the standard’s
implementation specifications or are not in the
standard’s implementation specifications,
or change the meaning or intent of the stand-
ard’s implementation specifications.

(6) The entity uses existing market re-
search and proven best practices.

(7) The entity has a set of measures that
allow for the evaluation of their market im-
pact and public reporting of aggregate stake-
holder feedback.

(8) The entity supports nondiscrimination
and conflict of interest policies that dem-
strate commitment to open, fair, and non-
discriminatory practices.

(9) The entity allows for public reviews
and comment on updates of the companion
guide, including operating rules.

(c) IMPLEMENTATION.—The Secretary shall
adopt a single, binding companion guide, in-
cluding operating rules under this section,
for each transaction, to become effective
with the X12 Version 5010 transaction imple-
mation, or as soon thereafter as feasible.

(f) EXPANSION OF PENALTY AUTHORITY.

The Secretary shall comply with section
1172, except that a nonprofit entity that
meets the standards guaranteeing access to affordable
health plan coverage, essential benefits, and other con-
sumer protections.

(b) REQUIREMENTS FOR QUALIFIED HEALTH
BENEFITS PLANS.—On or after the first day of
January 1, 2014, a health benefits plan shall not be
considered a qualified health benefits plan under this
division unless the plan meets the applicable
requirements of the following new paragraphs for
the type of plan and plan year involved:

(1) Subtitle B (relating to affordable cov-
erage, essential benefits, and other con-
sumer protections).

(2) Subtitle C (relating to essential bene-
fits).

(3) Subtitle D (relating to consumer pro-
tection).

(c) EXPANSION OF PENALTY AUTHORITY.—
The Secretary shall be authorized to im-
pose, in the case of a health care provider,
penalties provided under subsections (a) and (b),
for violations of this part that are comparable—

(1) In the case of health plans, to the
sanctions the Secretary is authorized to
impose under part C or D of title XVIII in
the case of a plan that violates a provision of
such plan under this part.

(2) In the case of a health care provider,
for violations of this part that are comparable
to the sanctions the Secretary is authorized to
impose under part C or D of title XVIII in
the case of a plan that violates a provision of
such plan under this part.

TITLII—PROTECTIONS AND STANDARDS
FOR QUALIFIED HEALTH BENEFITS
PLANS

Subtitle A—General Standards

SEC. 201. REQUIREMENTS REFORMING HEALTH
INSURANCE MARKETPLACE.

(a) PURPOSE.—The purpose of this title is
to establish standards to ensure that new
health insurance coverage and employment-

be treated as being ‘‘enrolled’’ in an employment-

in such plan.

(b) REQUIREMENTS FOR QUALIFIED HEALTH
BENEFITS PLANS.—On or after the first day of
Y1, a health benefits plan shall not be a
qualified health benefits plan under this
division unless the plan meets the applicable
requirements of the following new paragraphs for
the type of plan and plan year involved:

(1) Subtitle B (relating to affordable cov-
erage).

(2) Subtitle C (relating to essential bene-
fits).

(3) Subtitle D (relating to consumer pro-
tection).

(c) EXPANSION OF PENALTY AUTHORITY.—
The Secretary shall be authorized to impose
penalties provided under subsections (a) and (b),
for violations of this part that are comparable—

(1) In the case of health plans, to the
sanctions the Secretary is authorized to
impose under part C or D of title XVIII in
the case of a plan that violates a provision of
such plan.

(2) In the case of a health care provider,
for violations of this part that are comparable
to the sanctions the Secretary is authorized to
impose under part C or D of title XVIII in
the case of a plan that violates a provision of
such plan.
(a) GRANDFATHERED HEALTH INSURANCE COVERAGE.—Subject to the provisions of this subsection, an insurance policy, contract, individual health insurance coverage, or group health insurance coverage, whether offered to individuals or groups, that is in force and effect before the first day of Y1 and is not grandfathered through provision (1) or (2); and (2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Nothing in—

(A) paragraph (1) shall prevent the offering of excepted benefits described in section 2701(b)(1)(A) of the Public Health Service Act; and (B) this division shall be construed—

(i) to prevent the offering of a stand-alone plan that offers coverage of excepted benefits (as defined in section 2701(b)(1)(A) of the Public Health Service Act (relating to limited scope dental or vision benefits) for individuals and families from a State-licensed dental and vision carrier; or
(ii) as applying requirements for a qualified health benefits plan to such a stand-alone plan that is offered and priced separately from a qualified health insurance benefits plan.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 211. PROHIBITING PREEXISTING CONDITION EXCLUSION.

A qualified health benefits plan may not impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose material limitations on the coverage under the plan with respect to an individual or dependent based on any of the following:

(1) health status, medical condition, claims experience, rating area, geographic history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or any similar factors.

SEC. 212. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS AND PROHIBITION OF DISCRIMINATORY RATING.

The requirements of sections 2711 (other than subsections (e) and (f)) and 2712 (other than paragraphs (3) and (6) of subsection (b)) of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or through a health plan of a midsize employer, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such section 2712(c) nonrenewal or discontinuation of coverage, the issuer has not provided the enrollee with notice of nonpayment of premiums and there is a reasonable period during which the enrollee has had the opportunity to correct such nonpayment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in section 2711(c).

SEC. 213. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for a qualified health benefits plan that is health insurance coverage may not vary except as follows:

(B) by area.—By premium rating area (as permitted by State insurance regulators or, in the case of Exchange-participating health plans, as specified by the Commissioner).

(c) LIMITATIONS ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

(i) In general.—Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may not be issued or renewed as of the first day of Y1 as an Exchange-participating health plan.

(b) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.

(1) IN GENERAL.—The Commissioner shall base the basic per enrollee, on a per month cost, determined on an average actuarial value of the separate from health insurance coverage, and;

(2) By family enrollment.—By family enrollment (such as variations within categories and compositions of families) so long as such benefits are offered outside the health insurance Exchange and are priced separately from health insurance coverage;

(B) this division shall be construed—

(ii) as applying requirements for a qualified health benefits plan to such a stand-alone plan that is offered and priced separately from a qualified health insurance benefits plan.
SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) IN GENERAL.—A qualified health benefits plan that offers provider network coverage for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such provider networks to ensure access to such items and services and transparency in the cost-sharing differentials among providers participating in the network and policies regarding the management of such provider networks.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a conspicuous and readily accessible listing of all providers in its network on its Website and such data shall be available on the Health Insurance Exchange Website as a part of the information on that plan. The Commissioner shall also establish an online system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) PROVIDERS NETWORK DEFINED.—In this division, the term “provider network” means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNEMPLOYED ADULTS.

(a) IN GENERAL.—A qualified health benefits plan shall make available, at the option of the principal enrollee under the plan, coverage to the child of a qualified child (as defined in subsection (b)) of the enrollee.

(b) QUALIFIED CHILD DEFINED.—In this section, the term “qualified child” means, with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

(2) is enrolled in a health benefits plan other than under this section.

(c) PREMIUMS.—Nothing in this section shall be construed as preventing a qualified health benefits plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Commissioner based upon family size under section 213(a)(3).

SEC. 217. CONSISTENCY OF COSTS AND COVERAGE REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

In the case of health insurance coverage offered under a qualified health benefits plan, if the coverage decreases or the cost-sharing increases, the issuer of the coverage shall notify enrollees of the change at least 90 days before the change takes effect (or such shorter period of time in cases where the change is necessary to ensure the health and safety of enrollees and their families).

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGES.

(a) IN GENERAL.—A qualified health benefits plan shall provide coverage that at least meets the benefit standards adopted under section 224, to ensure the provision of quality health care and financial security, that—

(1) provides for the items and services described in subsection (b) in accordance with such benefit standards, consistent with subsection (c);

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limits on the coverage of covered health care items and services;

(4) complies with section 215(a) (relating to network adequacy); and

(5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1.

In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefit levels of employers, including multemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

(b) MINIMUM SERVICES TO BE COVERED.—Subject to subsection (d), the items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals, including services described in paragraph (4).

(4) Such services, equipment, and supplies incident to the services of a physician’s or a health professional’s delivery of care in inpatient or outpatient settings, including physician offices, patients’ homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services submitted to the Secretary of Health and Human Services and those vaccines recommended with a grade of A or B by the Task Force on Clinical Preventive Services.

(9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for—

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services described in paragraph (4)(A) or (4)(B) and the QHPB offering entity shall determine whether such coverage is provided.

(2) ANNUAL LIMITATION.—The applicable level specified in this subparagraph meets the annual limitation required under paragraph (3).

(d) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(e) MINIMUM ACTUARIAL VALUE.—

(1) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(2) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) ASSESSMENT AND COUNSELING FOR DOMESTIC VIOLENCE.—The Secretary shall support the need for an assessment and brief counseling for domestic violence as part of a behavioral health assessment or primary care visit and determine the appropriate coverage for such assessment and counseling.

(e) ABDICATION COVERAGE PROHIBITED AS PART OF MINIMUM BENEFITS PACKAGE.—

(1) PROHIBITION OF REQUIRED COVERAGE.—The Health Benefits Advisory Committee may not recommend under section 223(b), and the Secretary may not adopt in standards under section 224(b), the services described in paragraph (5)(A) of the essential benefits package and the Commissioner may not require such services for qualified health benefits plans to participate in the Health Insurance Exchange.

(2) VOLUNTARY CHOICE OF COVERAGE BY PLAN.—In the case of a qualified health benefits plan, the plan is not required (or prohibited) under this Act from providing coverage of services described in paragraph (4)(A) or (4)(B) and the QHPB offering entity shall determine whether such coverage is provided.
(3) Coverage under public health insurance option.—The public health insurance option shall provide coverage for services described in paragraph (4)(B). Nothing in this Act shall affect any provision of law preventing or prohibiting coverage of services described in paragraph (4)(A).

(4) Terms.—
(A) Abortions for which public funding is prohibited.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(B) Abortions for which public funding is allowed.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(1) Report regarding inclusion of oral health care in essential benefits package.—(A) Nine members who are not Federal employees and of the Health Benefits Advisory Committee shall serve without additional pay.

(B) The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee.

(2) Membership.—The Health Benefits Advisory Committee shall consist of the following members, in addition to the Surgeon General:

(A) Nine members who are not Federal employees or officers and who are appointed by the President.

(B) Nine members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1865(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint.

(3) Terms.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term of appointment for all such members.

(4) Duties.—
(A) Recommendations on benefit standards.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services this subtitle referred to as the ‘‘Secretary’’ benefit standards (as defined in paragraph (5)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health disparities.

(B) Periodic updating standards.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(5) State input.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act.

(6) Public input.—The Health Benefits Advisory Committee shall allow for public participation in the development of recommendations under this subsection.

(4) Level of cost-sharing for enhanced and premium plans.—
(A) Enhanced plan.—The level of cost-sharing for enhanced and premium plans shall be within the meaning of section 202(a) of the National Health Care Quality Act (5 U.S.C. App.).

(B) Premium.—The level of cost-sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 222(c)(3)(B).

(C) Operations.—
(1) Per diem pay.—Each member of the Health Benefits Advisory Committee shall receive a per diem, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code, and shall otherwise serve without pay.

(2) Members not treated as Federal employees.—Members of the Health Benefits Advisory Committee shall not be considered employees of the Federal Government solely by reason of any service on the Committee, except such members shall be considered to be within the meaning of section 222(c)(3)(B) of title 5, United States Code, for the purposes of disclosure and management of conflicts of interest.

(3) Application of FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the Health Benefits Advisory Committee.

(4) Publication.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet Website of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 224. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) Process for adoption of recommendations.—

(1) Review of recommended standards.—Not later than 45 days after the date of receipt of benefit standards recommended under section 223 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

(2) Determination to adopt standards.—If the Secretary determines—

(A) to propose adoption of benefit standards so recommended as a package, the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of such standards; or

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) Contingency.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553(f) of title 5, United States Code, propose adoption of initial benefit standards by such date.

(4) Publication.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under this subsection.

(b) Adoption of standards.—

(1) Initial standards.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall, through the rulemaking process consistent with subsection (a), adopt an initial set of benefit standards.

(2) Periodic updating standards.—Under subsection (a), the Secretary shall provide for the periodic updating of the benefit standards previously adopted under this section.

(3) Requirement.—The Secretary may not adopt any benefit standards for Federal Employees Health Benefits Act or package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 222 (including subsection (e)) and 229(b)(5).

Subtitle D—Additional Consumer Protections

SEC. 231. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

The Commissioner shall establish uniform marketing standards that all QHPB offering entities shall meet with respect to qualified health benefits plans that are health insurance coverage.

SEC. 232. REQUIRING FAIR GRIEVANCE AND APPEALS MACHINERY.

(a) General.—A QHPB offering entity shall provide for timely grievance and appeals mechanisms with respect to qualified health benefits plans that the Commissioner shall establish consistent with this section.

The Commissioner shall establish time limits for each of such mechanisms and implement them in a manner that is protective to the interests of patients.

(b) Internal Claims and Appeals Procedures.—Under a qualified health benefits plan,
the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth in 42 CFR 412.5 through 412.8 of the Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update the procedures in accordance with any standards that the Commissioner may establish.

(c) External Review Process.—

The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent review of covered claims. Such review shall be conducted by a health care provider relating to reimbursement arrangements between such plan and such provider.

(c) PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.—

(1) IN GENERAL.—If a QHBP offering entity contracts with a pharmacy benefit manager or other entity (in this subsection referred to as a “PBM”) to manage prescription drug coverage or otherwise control prescription drug costs under a qualified health benefits plan, the PBM shall provide at least annually to the Commissioner and to the QHBP offering entity offering such plan the following information in a form and manner to be determined by the Commissioner: (A) Information on the number and total cost of prescriptions under the contract that are filled via mail order and at retail pharmacies.

(2) An estimate of aggregate average payments under the contract, per prescription and per individual, that are made to mail order and retail pharmacies, and the average amount, per prescription, that the PBM was paid by the plan for prescriptions filled at mail order pharmacies.

(3) An estimate of the aggregate average payment per prescription (weighted by prescription volume) under the contract for pharmaceutical manufacturers, including all rebates, discounts, prices concessions, or administrative, and other payments from pharmaceutical manufacturers, and a description of the types of payments, and the amount of these payments that were shared with the plan, and a description of the percentage of cases in which the PBM received such payments.

(4) Information on the overall percentage of generic drugs dispensed under the contract at retail and mail order pharmacies, and the percentage of cases in which a generic drug is dispensed when available.

(5) Information on the percentage and number of cases under the contract in which individuals were switched because of PBM policies or at the direct or indirect control of the PBM from a prescribed drug that had a lower cost to the entity paying for the drug that had a higher cost for the QHBP offering entity, the rationale for these switchings, and a description of the PBMs policies governing such switchings.

(2) Confidentiality of Information.—In information disclosed by a PBM to the Commissioner or a QHBP offering entity under this subsection, the information shall not be disclosed by the Commissioner or the QHBP offering entity in a form which discloses the identity of a specific PBM or a specific PBM, or a specific retailer, manufacturer, or wholesaler, except only by the Commissioner: (A) to permit State or Federal law enforcement authorities to conduct investigations provided for in this Act; (B) to permit the Comptroller General, the Medicare Payment Advisory Commission, or the Secretary of Health and Human Services to review the information provided; and (C) to permit the Congressional Budget Office to review the information provided.

(3) Annual Public Report.—On an annual basis the Commissioner shall provide a public report providing industrywide aggregate or average information to be used in assessing the overall impact of PBMs on prescription drug prices and spending. Such report shall not disclose the identity of a specific PBM, or prices charged by such PBM, or a specific retailer, manufacturer, wholesaler, or any other confidential or trade secret information.

(4) Penalties.—The provisions of subsection (b)(3) and (c) of section 226 shall apply to any PBM that fails to provide information required under subsection (a) or that knowingly provides false information in the same manner as such provision applies to any PBM that enters into an agreement with a QHBP offering entity under section 233 of this Act.

SEC. 238. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION LAWS.—

An offeror of qualified health benefits plans under section 226 shall be treated as a plan offered under title IX of the Social Security Act, except that the application of such administrative simplification laws to qualified health benefits plans under section 226 shall be determined by the Commissioner:

(a) in general.—The Commissioner shall:

(1) establish a plan for the dissemination of advance care planning information to participants and beneficiaries; and

(2) submit to Congress a report on actions needed to be taken by the Congress or the Secretary to protect providers from biased marketing and sales practices.

SEC. 239. STATE PROHIBITIONS ON DISCRIMINATION AGAINST HEALTH CARE PROFESSIONALS.—

This Act (and the amendments made by this Act) shall not be construed as superseding laws, as they now or hereinafter exist, of any State or jurisdiction designed to provide qualified health benefits plans in the same manner as a Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 240. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.—

(a) IN GENERAL.—The QHBP offering entity shall:

(1) shall provide for the dissemination of information related to end-of-life planning

SEC. 232. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.—

(a) Study.—The Secretary of Health and Human Services shall conduct a study on the use of physician prescriber information in sales and marketing practices of pharmaceutical manufacturers.

(b) Report.—Based on the study conducted under subsection (a), the Secretary shall submit to Congress a report on actions needed to be taken by the Congress or the Secretary to protect providers from biased marketing and sales practices.

SEC. 235. TIMELY PAYMENT OF CLAIMS.—

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to qualified health benefits plans offered in the same manner as a Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.
to individuals seeking enrollment in Exchange-participating health benefits plans offered through the Exchange;
(2) present such individuals with—
(A) an explanation of the advanced directives and physician’s orders for life sustaining treatment or other end-of-life planning document;
(B) information related to other planning tools; and
(C) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under paragraph (2) shall not presume the withdrawal of treatment or the withholding of nutrition or hydration information that includes options to maintain all or most medical interventions.

Construction—Nothing in this section shall be construed to—
(1) require an individual to complete an advanced directive or a physician’s order for life sustaining treatment or other end-of-life planning document;
(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise offered under qualified health plans; or
(3) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(2) DEFINED TERM.—In this section, the term “advanced directive” includes a living will, a comfort care order, or a durable power of attorney for health care.

(d) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing.

(2) EXAMINED DEFINED.—In this section, the term “advanced directive” includes a living will, a comfort care order, or a durable power of attorney for health care.

(2) CONSTRUCTION.—Nothing in this section shall be construed to apply to or affect any other law or regulation that—
(A) with respect to the administration of qualified health benefits plans offered by a QHBP offering entity, includes an item, good, benefit, or service furnished under section 1311 of the Patient Protection and Affordable Care Act (as added by section 201 of Public Law 111–148 (42 U.S.C. 18001));
(B) withhold or withdraw of nutrition or hydration;

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(1) IN GENERAL.—In the case that the Commissioner determines that a QHBP offering entity has failed to comply with paragraphs (2), (4), or (6) of subsection (a), the Commissioner may, in coordination with State insurance regulators and the Secretary, take such actions as are necessary to enforce the requirements of this title and enforce the provisions of the Commissioner's duties under this division, including with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 308 and 341(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

(2) CONSULTATION.—The Commissioner shall consult in carrying out the Commissioner’s duties under this division, the Commissioner, as appropriate, shall consult at least with the following:

(1) State attorneys general and State insurance regulators, including concerning the standards for health insurance coverage that is a qualified health benefit plan under this title and enforcement of such standards.

(2) The National Association of Insurance Commissioners, including for purposes of using model guidelines established by such association for purposes of applying such standards.

(3) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of this title and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(4) The Federal Trade Commission, specifically concerning the development and issuance of guidance, rules, or standards regarding fair marketing practices under section 1322 or otherwise, and consumer disclosure requirements under section 233 or otherwise.

(5) Other appropriate Federal agencies.

(6) Indian tribes and tribal organizations.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible and consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner shall ensure that, in coordination with such entities, the Commissioner shall adopt uniform standards that adequately protect consumers in a manner that does not unreasonably affect employers and insurers.

SEC. 244. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Health Insurance Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals.

(b) DUTIES.—The Commissioner shall—
(1) establish an Office of the Inspector General for the Health Choices Administration, see section 1677.

(c) INSPECTOR GENERAL.—For provision establishing an Office of the Inspector General for the Health Choices Administration, see section 1677.

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) DUTIES.—The Commissioner is responsible for—

(1) QUALIFIED PLAN STANDARDS.—Establishment of qualified health plans standards and enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH INSURANCE EXCHANGE.—Establishment and operation of a Health Insurance Exchange under subtitle A of title III.

(3) INDIVIDUAL AFFORDABILITY CREDITS.—The administration of individual affordability credits under subtitle C of title III, including determination of eligibility for such credits.

(4) ADDITIONAL FUNCTIONS.—Such additional functions as may be specified in this division.

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(1) IN GENERAL.—The Commissioner shall, in coordination with States, conduct audits of qualified health plans or qualified health plan issuers with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspicious situations.

(2) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner shall collect data for purposes of carrying out the Commissioner’s duties, including for purposes of promoting quality and value, protecting consumers, and avoiding adverse effects on health and health care and may share such data with the Secretary of Health and Human Services.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—The Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph, with respect to a qualified health benefit plan offered by a QHBP offering entity, are—

(A) civil money penalties of not more than the amount that would be applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act;

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment of the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur;

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the requirements of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standards, definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 308 and 341(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 243. CONSULTATION AND COORDINATION.

(a) IN GENERAL.—The Commissioner shall consult in carrying out the Commissioner’s duties under this division, the Commissioner, as appropriate, shall consult at least with the following:

(1) State attorneys general and State insurance regulators, including concerning the standards for health insurance coverage that is a qualified health benefit plan under this title and enforcement of such standards.

(2) The National Association of Insurance Commissioners, including for purposes of using model guidelines established by such association for purposes of applying such standards.

(3) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of this title and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(4) The Federal Trade Commission, specifically concerning the development and issuance of guidance, rules, or standards regarding fair marketing practices under section 1322 or otherwise, and consumer disclosure requirements under section 233 or otherwise.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner shall ensure that, in coordination with such entities, the Commissioner shall adopt uniform standards that adequately protect consumers in a manner that does not unreasonably affect employers and insurers.

(c) INSPECTOR GENERAL.—For provision establishing an Office of the Inspector General for the Health Choices Administration, see section 1677.
(1) receive complaints, grievances, and requests for information submitted by individuals through means such as the mail, telephone, electronically, and in person;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant requirements to seek an appeal of a decision or determination;

(B) assistance to such individuals in choosing a qualified health benefits plan in which to enroll;

(C) assistance to such individuals with any problems arising from disenrollment from such a plan; and

(D) providing such assistance to such individuals in presenting information under subtitle C (relating to affordability credits); and

(3) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 251. RELATION TO OTHER REQUIREMENTS; MISCELLANEOUS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered through an employer-based health plan), and in the case of employment-based health plans, the requirements of this title do not superecede any requirements applicable under title XVIII, parts 6 and 7 of subtitle B of title I of the Social Security Act, or part 1871 of the Employee Retirement Income Security Act of 1974.

(2) CONSTRUCTION.—In the case of coverage not offered through the Health Insurance Exchange—

(B) willingness or refusal to provide abortion or to provide or participate in an assisted suicide; and

(c) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate official of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange:

(A) the requirements of this title do not superecede any requirements (including requirements relating to genetic information nondiscrimination and mental health parity) applicable under title XVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

(B) individual rights and remedies under State laws shall apply.

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State law to the extent that such rights and remedies under State law with respect to requirements applicable to employers or other plan sponsors in connection with arrangements which are otherwise regulated under group health plans under section 823(a)(1) of the Employee Retirement Income Security Act of 1974.

SEC. 252. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations promulgated thereunder, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to any characteristic extraneous to the provision of high quality health care or related services.

(b) IMPLEMENTATION.—To implement the requirement set forth in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including insurance coverage and public health activities) covered by this Act are provided (whether directly or through contractual, licensing, or other arrangements) without regard to personal characteristics extraneous to the provision of high quality health care or related services.

SEC. 253. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge, or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee—

(1) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State a information under subtitle C (relating to affordability credits); and

(2) testifies or is about to testify in a proceeding concerning such violation; or

(3) assisted or participated or is about to assist or participate in such a proceeding; or

(4) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act; or

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of section (a) shall be entitled to remedies set forth in section 514(b) of the Consumer Product Safety Act (15 U.S.C. 2060) or section 514(b)(5) of the Consumer Product Safety Act (15 U.S.C. 2060).

(c) EMPLOYEE DEFINED.—As used in this section, the term ‘‘employee’’ means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization, including a certification, disciplinary, or other professional body, unincorporated organization or professional organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

(d) RULE OF CONSTRUCTION.—The rule of construction set forth in section 20109(h) of title 29, United States Code, shall also apply to this section.

SEC. 254. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

(a) NOTHING IN THIS SECTION SHALL BE CONSTRUED.—Nothing in this section shall be construed to alter or supersede any statutory or other obligation to engage in collective bargaining over the terms or conditions of employment of individuals employed by an employer, the employee or employee's representative, making the plan, or the employer and the employee or employee's representative, made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this division shall not be treated as a termination of such collective bargaining agreement.

(b) SEVERABILITY.—If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, invalid, or inapplicable or its invalid under the laws of the United States or any State to the extent that it is held invalid, the application of the provision to any other person or circumstance shall not be affected.

SEC. 256. TREATMENT OF HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)), and such exemption shall also apply with respect to the provisions of this division; and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate official of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 257. ACTIONS BY STATE ATTORNEYS GENERAL.

Any State attorney general may bring a civil action in the name of such State as parens patriae on behalf of natural persons residing in such State, in any district court of the United States having jurisdiction of the defendant to secure monetary or equitable relief for violation of any provisions of this title or regulations issued thereunder. Nothing in this section shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

SEC. 258. APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.

(a) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortion, including consent for the performance of an abortion on a minor.

(b) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—(1) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(A) conscience protection;

(B) willingness or refusal to provide abortion; and

(C) discrimination on the basis of the willingness or refusal to provide abortion or to refer for abortion or to provide or participate in training to provide abortion.
(c) No effect on Federal Civil Rights Law.—Nothing in this section shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

SEC. 259. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

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

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

(2) require any health plan created or regulated under this Act to subject any individual or institutional health care entity to discrimination.

(b) Definition.—In this section, the term ‘health care entity’ includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance provider, a provider of other health care, a provider of institutional health care, a provider of medical malpractice insurance, a provider of medical malpractice services if doing so does not involve a restraint of trade.

(c) Enforcement.—The Office for Civil Rights of the Department of Health and Human Services shall enforce this section.

SEC. 260. AUTHORITY OF FEDERAL TRADE COMMISSION.

Section 6 of the Federal Trade Commission Act (15 U.S.C. 45) is amended by striking ‘and prepare reappraisals’ and inserting the following: ‘and prepare reappraisals and determine the authenticity of the claims submitted and any adjustment to the aggregate of losses incurred during a period that will ultimately be paid.’

SEC. 261. CONSTRUCTION REGARDING STANDARDS OF CARE.

(a) In General.—The development, recognition, or implementation of any guideline or standard of care required or permitted by any provision described in subsection (b) shall not be construed to establish the standard of care for duty of care owed by health care providers to their patients in any medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))).

(b) Provisions Described.—The provisions described in this subsection are the following:

(1) Section 234 (relating to maximum payment to providers under the public health option).

(2) The amendments made by section 1151 (relating to reducing potentially preventable hospital readmissions).

(3) The amendments made by section 1751 (relating to the Task Force on Clinical Preventive Services).

(4) Section 3311 of the Public Health Service Act (relating to implementation of best practices in the delivery of health care), added by section 2301.

(c) Savings Clause for State Medical Malpractice Law.—Nothing in this section shall preclude the application of the amendments made by this Act shall be construed to modify or impair State law governing legal standards or procedures used in medical malpractice cases, including the authority of a State to make or implement such laws.

SEC. 262. RESTORING APPLICATION OF ANTI-TRUST LAWS TO HEALTH SECTOR INJURIES.

(a) Amendment to McCarran-Ferguson Act.—Section 2(b) of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

‘(c1) Except as provided in paragraph (2), nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance or the business of medical malpractice insurance.

‘(2) Paragraph 1 shall not apply to—

(A) collecting, verifying, or disseminating historical loss data;

(B) determining a loss development factor applicable to historical loss data; or

(C) performing actuarial services if doing so does not involve a restraint of trade.

(b) Conforming Amendment.—The amendment made by subsection (a) shall be made to the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

‘(C) the term ‘loss development factor’ means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received and reserves are being accumulated to estimate the aggregate of the losses incurred during such period that will ultimately be paid.’

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance, and with respect to the business of medical malpractice insurance, without regard to whether such business is carried on for profit, notwithstanding the term includes section 5 of the Federal Trade Commission Act to the extent that such section applies to unfair methods of competition.

(c) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of medical malpractice insurance, without regard to whether such business is carried on for profit, notwithstanding the term includes section 5 of the Federal Trade Commission Act to the extent that such section applies to unfair methods of competition.

SEC. 263. STUDY AND REPORT ON METHODS TO INCREASE EHR USE BY SMALL HEALTH CARE PROVIDERS.

(a) Study.—The Secretary of Health and Human Services shall conduct a study of potential methods to increase the use of qualified electronic health records (as defined in section 1790(ii)(4) of the Social Security Act) by small health care providers. Such study shall consider at least the following methods:

(1) Providing for higher rates of reimbursements or other incentives for such health care providers to use electronic health records (taking into consideration initiatives by private entities and other entities to provide rebates and other incentives provided under Medicare under title XVIII of the Social Security Act, Medicaid

(b) Report.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subsection (a), including recommendations for legislation or administrative action to increase the use of electronic health records by small health care providers that include the use of both public and private funding sources.

SECTION 264. PREFRAMESSMENT ASSESSMENT AND ACCOUNTABILITY: APPLICATION OF ANTI-TRUST LAWS AND RELATED REGULATIONS

(a) Application of GPRA.—Section 306 of title 5, United States Code, and sections 1115, 1116, and 9005 of the Energy Policy Act of 1992 (42 U.S.C. 1951d and 9005l), and section 103 of the Government Performance and Results Act of 1993, Public Law 103–62) apply to the executive agencies established under this Act, to the Health Care Choices Administration. Under such section 306, each such executive agency is required to provide for a strategic plan every 3 years.

(b) Improving Consumer Service and Streamlining Procedures.—Every 3 years each such executive agency shall—

(1) assess the quality of customer service provided, (2) develop a strategy for improving such service, and (3) establish standards for high-quality customer service; and

(c) Related Preservation of Antitrust Laws.—Nothing in this Act shall—

(1) modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance or the business of medical malpractice services if doing so does not involve a restraint of trade.

(2) modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance or the business of medical malpractice services if doing so does not involve a restraint of trade.

(d) Performance Assessment and Results.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 231(b), the Commissioner shall—

(1) under section 304 establish standards for, accept bids from, and negotiate and enter into contracts with, QHP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required and including a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

SEC. 265. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

(a) Establishment.—There is established within the Health Choices Administration an entity to provide individuals and employers a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 231(b), the Commissioner shall—

(1) establish standards for, accept bids from, and negotiate and enter into contracts with, QHP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required and including a public health insurance option.

(c) savings clause for state medical malpractice law.—Nothing in this section shall preclude the application of the amendments made by this Act shall be construed to modify or impair State law governing legal standards or procedures used in medical malpractice cases, including the authority of a State to make or implement such laws.

(d) Access to Coverage.—In accordance with this section, all individuals are eligible

SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS

(a) Access to Coverage.—In accordance with this section, all individuals are eligible

November 7, 2009

H12641

CONGRESSIONAL RECORD — HOUSE
to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Health Insurance Exchange unless such individuals are enrolled in one qualified health benefits plan or certain other acceptable coverage.

(b) Definitions.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term "exchange-eligible individual" means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term "Exchange-eligible employer" means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms "employee", "employee", "full-time employee", and "part-time employee" have the meanings given such terms by the Commissioner for purposes of this division.

(4) DEFINITIONS.—The following definitions apply for purposes of this division:

(a) Individuals and employers shall only be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following transition schedule:

(1) Phase-In.—In Y1 (as defined in section 100(c))—

(A) individuals described in subsection (d)(1), including individuals described in subsection (b)(1) who are not eligible and enrolled in Exchange-eligible health benefits plans;

(B) small employers described in subsection (e)(1);

(2) SECOND YEAR.—In Y2—

(A) individuals and employers described in paragraph (1); and

(B) small employers described in subsection (e)(2).

(3) THIRD AND SUBSEQUENT YEARS.—In Y3—

(A) individuals and employers described in paragraph (2);

(B) small employers described in subsection (e)(3); and

(C) larger employers as permitted by the Commissioner under subsection (e)(4).

(4) INDIVIDUALS.—

(A) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who:

(i) is not enrolled in coverage described in subparagraph (C) or (D) of paragraph (2); and

(ii) is not enrolled in coverage as a full-time employee (as defined in such paragraph) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 412.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirements of section 412, such individual shall be deemed a full-time employee described in such subparagraph.

(2) ACCEPTABLE COVERAGE.—For purposes of this paragraph, "acceptable coverage" means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDPARENTED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandparented health insurance coverage (as defined in subsection (a) of section 202) or under a current group health plan (described in subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title X of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (2), or (aa), or (hh) of section 1902 of such Act.

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TERRITORIES).—Coverage for a member of the Armed Forces and not otherwise offered through the Health Insurance Exchange, including similar coverage furnished under section 7701 of title 38 of such Code.

(F) VA.—Coverage if the individual is a veteran of the Health care program under chapter 17 of title 38, United States Code.

(G) OTHER COVERAGE.—Such other health benefits coverage as the Commissioner, in coordination with the Secretary of Veterans Affairs, recognizes for purposes of this subsection.

The Commissioner shall make determinations under this paragraph in coordination with the Secretary of Veterans Affairs.

(3) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under paragraph (2), such individual shall continue to be treated as an Exchange-eligible individual until the individual is no longer enrolled with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

(1) IN GENERAL.—Subparagraph (A) shall not apply to an individual once the individual becomes eligible for coverage—

(i) under part A of the Medicare program;

(ii) under the Medicaid program as a Medicaid-eligible individual, except as permitted under clause (i); or

(iii) in such other circumstances as the Commissioner shall by regulation prescribe.

(2) TRANSITION PERIOD.—In the case described in clause (i)(I), the Commissioner shall permit the individual to continue treatment under subparagraph (A) until such limited time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual's access to health care.

(4) TRANSITION FOR CHIP ELIGIBLES.—An individual who is eligible for child health assistance under title XXI of the Social Security Act for a period during Y1 shall not be an Exchange-eligible individual during such period.

(e) EMPLOYERS.—

(1) SMOLEST EMPLOYER.—Subject to paragraph (5), smaller employers described in this paragraph are employers with 25 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (5), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and have 50 or fewer employees.

(3) SMALL EMPLOYERS.—Subject to paragraph (5), small employers described in this paragraph are employers that are not described in paragraph (1) or (2) and have 100 or fewer employees.

(f) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The Commissioner shall conduct regular surveys of exchange-eligible individuals and employers concerning satisfaction of such individuals and employers with the Health Insurance Exchange and Exchange-participating health benefits plans.

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individual and for employers, including individuals and employers with, and for individuals and employers without, Exchange-eligible participation status, and to establish grace periods for premium payment.
Exchange compared to Exchange-participating health benefits plans; and
(B) the affordability-test standard for ac-
cess of certain employed individuals to cov-
erage in the Health Insurance Exchange.
(3) REPORT.—Not later than January 1 of
Y3, in Y6, and thereafter, the Commissioner
shall submit to Congress a report on the study
conducted under this subsection and shall include in such report recommenda-
tions regarding changes in standards for
Exchange eligibility for individuals and em-
ployers.
SEC. 303. BENEFITS PACKAGE LEVELS.
(a) IN GENERAL.—The Commissioner shall
specify the benefits to be made available
under Exchange-participating health bene-
fits plans during each plan year, consistent
with subtitle C of title II and this section.
(b) LIMITATIONS ON HEALTH BENEFITS PLANS
OFFERED BY OFFERING ENTITIES.—The Com-
misioner may not enter into a contract with
a QHBP offering entity under section 306(b)
for the offering of Exchange-participating
health benefits plan in a service area unless the following requirements are met:
(1) REQUIRED OFFERING OF BASIC PLAN.—The entity
shall offer only one basic plan for such
service area.
(2) OPTIONAL OFFERING OF ENHANCED PLAN.—If the entity offers a basic plan for such service area, the entity may
offer one enhanced plan for such area.
(3) OPTIONAL OFFERING OF PREMIUM PLAN.—If the entity offers an enhanced plan for such service area, the entity may
offer one premium plan for such area.
(4) OPTIONAL OFFERING OF PREMIUM-PLUS PLANS.—If
the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area.
All such plans may be offered under a single
contract with the Commissioner.
(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—
(1) IN GENERAL.—The Commissioner shall establish the following standards consistent with this subsection and title II:
(A) BASIC, ENHANCED, AND PREMIUM PLANS.—Standards for 3 levels of Exchange-participating health benefits plans:
(b) PREMIUM-PLUS PLAN BENEFITS.—Standards for additional benefits that may be of-
ered to, this subsection and title II:
(1) BASIC PLAN.—A basic plan shall offer the essential benefits package required under
title II for qualified health benefits plan with an actuarial value of 70 percent of the
full actuarial value of the benefits pro-
vided under the reference benefits package.
(2) ENHANCED PLAN.—An enhanced plan shall offer, in addition to the level of bene-
fits under the basic plan, a lower level of
cost-sharing as provided under title II con-
sistent with section 223(b)(5)(A).
(3) PREMIUM PLAN.—A premium plan shall
offer, in addition to the level of benefits under the enhanced plan, a lower level of
cost-sharing as provided under title II consistent
with section 223(b)(5)(B).
(4) PREMIUM-PLUS PLAN.—A premium-plus plan is a premium plan that also provides ad-
ditional benefits, such as adult oral health
and vision care, approved by the Commis-
sioner that is attributable to such additional benefits shall be
specified separately.
(5) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of
cost-sharing for each basic, enhanced, and
premium plan, except with respect to any
benefit for which there is no cost-sharing
permitted under the essential benefits pack-
age. Such variation shall permit a variation
of not more than plus (or minus) 10 percent
in cost-sharing in each benefit category specified under section 222. Nothing in this
to be separately construed as prob-
in cost-sharing, including through preferred and participating pro-
viders and prescription drugs. In applying
this paragraph, a health benefits plan may
increase the cost-sharing by 10 percent with-
in each category or tier, as applicable, and
may decrease or eliminate cost-sharing in
any category or tier as compared to the es-
ential benefits package.
(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance
coverage to include benefits beyond the es-
ential benefits package, the requirement shall continue to apply to an Exchange-par-
ticipating health benefits plan, if the State
has entered into an arrangement satisfac-
tory to the Commissioner to reimburse the
Commissioner for the amount of any net in-
crease in affordability premium credits under subtitle C as a result of an increase in
premium in benefits plans, as a result of a result of application of such requirement.
(e) RULES REGARDING COVERAGE OF AND AFFORD-
ABILITY CREDITS FOR SPECIFIED SERVICES.—
(1) ASSURED AVAILABILITY OF VARIED CO-
VERAGE THROUGH THE HEALTH INSURANCE EX-
CHANGE.—The Commissioner shall assure
that, of the Exchange-participating health
benefits plans offered in each premium rat-
ing area of the Health Insurance Exchange—
(A) there is at least one such plan that pro-
vides coverage of services described in subsections (A) and (B) of section 222(e)(4); and
(B) there is at least one such plan that pro-
vides for affordable premiums.
(2) DATA REPORTING.—The entity shall pro-
vide information necessary to administer the risk
pooling mechanism described in section 334(c),
including in information to address disparities in health and health care.
(3) AFFORDABILITY.—The entity shall pro-
vide for affordable premiums.
(f) IMPLEMENTATION OF AFFORDABILITY CRED-
ITS.—The entity shall provide for implementa-
tion of the affordability credits provided for enrollees under subtitle C, including the
reduction in cost-sharing under section 344(c).
(5) ENROLLMENT.—The entity shall accept all
enrollments under this subtitle, subject to
such exceptions (such as capacity limita-
tions) in accordance with the requirements
under title II for a qualified health benefits
plan. The entity shall notify the Commis-
sioner if the entity projects or anticipates
reaching such a capacity limitation that
would result in a limitation in enrollment.
(6) RISK POOLING MECHANISM.—The entity
shall participate in such risk pooling
mechanism as the Commissioner establishes
under section 306(b).
(7) ESSENTIAL COMMUNITY PROVIDERS.—With re-
spect to any plan offered by the entity, the entity shall include within the plan
network those essential community
providers, where available, that serve predomin-
tly low-income, uninsured, and vulnerable
individuals, such as health care providers de-
ined in section 340B(a)(4) of the Public
Health Service Act and providers described
under title II of the Social Security Act (as amended by section 221 of
Public Law 111–8). The Commissioner shall
specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act. This paragraph shall not be construed to require a contract to contract with a provider if such provider refuses to accept the generally applicable payment rates of such plan.

4. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS. —The entity shall provide for culturally and linguistically appropriate communication and health services.

5. SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS.—

(a) Choice of Providers. —The entity shall—

(1) demonstrate to the satisfaction of the Commissioner that it has contracted with a sufficient number of Indian health care providers to ensure timely access to covered services furnished by such providers to individuals through the Exchange-participating health benefits plan; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered services provided to covered enrollees who are eligible for receivable services from such providers at a rate that is not less than the level and amount of payment which the entity would make for the services of a participating provider which is not an Indian health care provider.

(b) Special Rule relating to Indian Health Care Providers. — Provision of services by nonparticipating providers exclusively to Indians and their dependents shall not constitute discrimination under this Act.

6. PROGRAM INTEGRITY STANDARDS. —The entity shall establish and operate a program to protect and promote the integrity of Exchange-participating health benefits plans it offers, in accordance with standards and functions established by the Commissioner.

7. ADDITIONAL REQUIREMENTS. —The entity shall comply with all applicable requirements, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums, claims, and other amounts due under the plan, and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

8. CONTRACTS. —

(a) Bid Application. —To be eligible to enter into a contract under this section, a QHPB offering entity shall submit to the Commissioner a bid at such time, in such manner, and containing such information as the Commissioner requires.

(b) Term. —Each contract with a QHPB offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

9. ENFORCEMENT OF NETWORK ADEQUACY. —In the case of a health benefits plan of a QHPB offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 215; and

(B) an enrollee in such plan receives an item or service from a provider that is not within such network;

then any cost-sharing for such item or service shall be equal to the amount of such cost-sharing that would be imposed if such item or service was furnished by a provider within such network;

4. OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES. —The Commissioner shall establish processes, in coordination with State insurance regulators, a procedure under which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

5. Grievance and Complaint Mechanisms. —The Commissioner shall establish, in coordination with relevant State insurance regulators, a procedure under which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

6. Enforcement. —In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 242(d).

7. Termination. —

(a) In General. —The Commissioner may terminate a contract with a QHPB offering entity under the authority of this division if such entity fails to comply with the applicable requirements of this title.

(b) Notice. —The Commissioner shall provide such entity with reasonable notice and opportunity to respond to a proposed contract termination election within 30 days from the date of notice.

(c) Effective Date. —The termination shall take effect not later than 120 days after the date of the 30-day notice described above.

(d) Appeal. —The entity shall have the right to appeal a decision to terminate a contract under the procedures established by the Commissioner.

(e) Effect on Priorities. —Nothing in this section shall be construed to affect any other exchange-participating health benefits plans.

8. Program Integrity Standards. —

(a) In General. —The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (3) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other chronic impairments.

(b) Special Enrollment. —The Commissioner shall make timely determinations of whether individuals and employers are Exchange-eligible individuals and employers (as defined in section 392).

(c) Enrollment Periods. —

(1) Open Enrollment Period. —The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll, make changes to, or disenroll from an Exchange-eligible health benefits plan for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be durative, with one renewal period per year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be fewer than 30 days.

(d) Special Enrollment. —The Commissioner shall provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

(ii) experiences a change in marital or dependent status status;

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(e) Enrollment Information. —The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(f) Automatic Enrollment for Non-MedicAID Eligible Individuals. —

(A) In General. —The Commissioner shall provide for a process under which individuals
who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such enrollment shall involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) **SUBSIDIZED INDIVIDUALS DESCRIBED.**—An individual described in this subparagraph is Exchange-eligible individual who is either (A) a Medicaid eligible individual for purposes of this division and Medicaid; and (B) to be automatically enrolled in Medicaid as a traditional Medicaid eligible individual under section 1902(a)(7) of the Social Security Act.

(2) **EXTENDED TREATMENT AS MEDICAID ELIGIBLE INDIVIDUAL.**—In the case of a child described with regard to the enrollment of the child referred to in this paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child is otherwise covered under such acceptable coverage or the State otherwise makes a determination of the child’s eligibility for medical assistance under its Medicaid plan pursuant to section 1902(a)(7) of the Social Security Act) to be a Medicaid eligible individual described in section 1902(a)(7)(B) of such Act.

(e) **MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.**—

(1) **MEDICAID ENROLLMENT OBLIGATION.**—An individual may apply, in the manner described in section 341(b)(1), for a determination of whether the individual is a Medicaid eligible individual. If the individual is determined to be so eligible, the Commissioner, through such memorandum of understanding under paragraph (2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such State plan. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(2) **COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERTANDING.**—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State’s Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or eliminate any requirement of a State Medicaid plan.

(f) **EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.**—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

(g) **ROLE FOR ENROLLMENT AGENTS AND BROKERS.**—Nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefit plans that include the public health insurance option.

(h) **ASSISTANCE FOR SMALL EMPLOYERS.**—

(1) **DUTIES.**—The Commissioner in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers counseling, training, and technical assistance with respect to the provision of health insurance to employees of such employers through the Health Insurance Exchange.

(2) **INFORMATIONAL MEMORANDUM.**—The program established under paragraph (1) shall include the following: (A) Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options.

(b) **Distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health Insurance Exchange, the standardization and comparability information on the health plans available under the Health Insurance Exchange.

(c) **Distribution of information to small employers with respect to the affordability credits or other financial assistance.

(d) **Referrals to appropriate entities of complaints and questions relating to the Health Insurance Exchange.

(E) **Enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange.

(3) **AUTHORITY TO PROVIDE SERVICES DIRECTLY OR BY CONTRACT.**—The Commissioner may provide services under paragraph (2) directly or by contract with nonprofit entities that the Commissioner determines capable of—

(i) **SMALL EMPLOYER DEFINED.**—In this subsection, the term “small employer” means an employer with less than 100 employees.

(4) **PARTICIPATION OF SMALL EMPLOYER BENEFIT ARRANGEMENTS.**—

(1) **IN GENERAL.**—The Commissioner may enter into contracts with small employer benefit arrangements to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an arrangement under Exchange participating health benefits plans.

(2) **SMALL EMPLOYER BENEFIT ARRANGEMENT DEFINED.**—In this subsection, the term “small employer benefit arrangement” means a not-for-profit agricultural or other cooperative that—

(a) **COORDINATION OF AFFORDABILITY CREDITS.**—The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits under subtitle C to QHP offering entities offering Exchange-participating health benefits plans.

(b) **COORDINATION OF RISK POOLING.**—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans. The Commissioner shall ensure that data on premiums are collected for such plans that takes into account (in a manner specified by the Commissioner) the different characteristics of individuals and employees enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities. For purposes of the previous sentence, the Commissioner may utilize data regarding enrollee demographics, inpatient and outpatient, in a manner similar to which such data are used under parts C and D of title XVIII of the Social Security Act, and such other information as the Commissioner determines may be necessary, such as the actual medical costs of enrollees during the previous year.
SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) Establishment of Health Insurance Exchange Trust Fund.—There is created within the Treasury of the United States a trust fund to be known as the “Health Insurance Exchange Trust Fund” (in this section referred to as the “Trust Fund”). The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals) shall be credited to the Trust Fund.

(b) Use of Trust Fund.—The Commissioner shall pay from time to time from the Trust Fund such amounts as the Commissioner determines to make payments to create the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(c) Transfers to Trust Fund. — (1) In General. — There are hereby appropriated to the Trust Fund amounts equivalent to the following:

(A) Taxes on Individuals Not Obtaining Acceptable Coverage.—The amounts received in the Treasury under sections 5001 and 5002 of the Internal Revenue Code of 1986 (relating to employers and other persons failing to provide health coverage) shall be credited to the Trust Fund.

(B) Employment Taxes on Employers Not Providing Acceptable Coverage.—The amounts received in the Treasury under sections 5003 and 5004 of the Internal Revenue Code of 1986 (relating to employers and other persons failing to provide health coverage) shall be credited to the Trust Fund.

(C) Excise Tax on Failures to Meet Certain Requirements.—The amounts received in the Treasury under section 5602(b) (relating to excise tax with respect to failure to meet health coverage participation requirements) shall be credited to the Trust Fund.

(D) Appropriations to Cover Government Contributions.—There are hereby appropriated to the Trust Fund the amounts under paragraphs (1) and (2) of subsection (a).

(E) Application of Certain Rules.—Rules similar to the rules of subsection (c) of former section 201 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

(f) Funding.—In the case of a State-based Health Insurance Exchange, there shall be provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 308. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) In General.—If—

(1) a State (or group of States, subject to the Commissioner’s approval) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange, then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange only if the State meets the requirements for approval under subsection (b).

(b) Requirements for Approval.—

(1) In General.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(A) The State-based Health Insurance Exchange must demonstrate the capacity to provide and ship policies and other assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(i) negotiating and contracting with QHP offering entities for the offering of Exchange-participating health benefits plans, which satisfy the standards and requirements of this title and title II; and

(ii) enrolling Exchange-eligible individuals and employers in such State in such plans; and

(B) the State offers adequate local offices to meet the needs of Exchange-eligible individuals and employers, including—

(i) administering affordability credits under subsections (f) and (h) of title II; and

(ii) establishing a Health Insurance Authority to operate, instead of such State-based Health Insurance Exchange, an amount equivalent to the State authority for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

(c) States Electing to Not Provide Health Benefits.—For States electing to not provide health benefits, the Commissioner may specify functions, programs, and activities consistent with Federal requirements.

(d) Discretion to Retain Additional Authority.—The Commissioner may specify functions of the Health Insurance Exchange that—

(1) may not be performed by a State-based Health Insurance Exchange under this section; or

(2) may be performed by the Commissioner and such a State-based Health Insurance Exchange.

(e) References.—In the case of a State-based Health Insurance Exchange, references to the Commissioner in this subtitle shall be deemed a reference to the State-based Health Insurance Exchange and the Secretary in this subtitle to refer to the Secretary of Health and Human Services.

(f) Model Guidelines.—The Secretary shall consult with the National Association of Insurance Commissioners to develop guidelines similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 (relating to affordability credits).

(1) Taxes on Individuals Not Obtaining Acceptable Coverage.—The amounts received in the Treasury under sections 5001 and 5002 of the Internal Revenue Code of 1986 shall be credited to the Trust Fund under this section unless the Commissioner determines, after notice and opportunity for public hearing, that such an Exchange will not result in any net increase in expenditures to the Federal Government.

(2) States Electing to Not Provide Health Benefits.—The Secretary shall consult with States electing to not provide health benefits, to develop guidelines similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 (relating to affordability credits).

(3) In General.—In the case of a State operating an Exchange prior to January 1, 2010, that seeks to operate a State-based Health Insurance Exchange under this section, the Commissioner shall presume that such Exchange meets the standards under this section unless the Commissioner determines, after notice and opportunity for public hearing, that such Exchange does not comply with such standards.

(4) States Electing to Not Provide Health Benefits.—If the Commissioner determines that an Exchange does not comply with such standards, the Commissioner shall specify functions the State-based Health Insurance Exchange must perform.

(g) Payment of All Federal Requirements.—A State-based Health Insurance Exchange operates, instead of such State-based Health Insurance Exchange, with respect to a State (or group of States), if the Commissioner determines that—

(1) the establishment of sufficient local offices in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the Secretary in this subtitle to refer to the Secretary of Health and Human Services; and

(2) the purchase of individual health insurance coverage across State lines.

(h) Model Guidelines.—The Secretary shall consult with the National Association of Insurance Commissioners (in this section referred to as “NAIC”) to develop not later than January 1, 2014 model guidelines for the creation of model compacts. In developing such guidelines, the Secretary shall consult with consumers, health insurance issuers, and other interested parties. Such guidelines shall—

(i) provide for the regulation of all State-based health insurance coverage to residents of all compacting States subject to the laws and regulations of a primary State designated by the compacting States;

(2) require health insurance issuers issuing health insurance coverage in secondary States to maintain licensure in every such State;

(3) preserve the authority of the State of an individual’s residence to enforce law relating to—

(A) market conduct;

(B) unfair trade practices;

(C) network adequacy;

(D) consumer protection standards;

(E) grievance and appeals自理;

(F) fair claims payment requirements;

(G) prompt payment of claims;

(H) rate review; and

(I) fraud.

(3) permit State insurance commissioners and other State agencies in secondary States access to the records of a health insurance issuer to the same extent as if the policy were written in that State; and

(4) provide for clear and conspicuous disclosure to consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(i) No Requirement to Compact.—Nothing in this section shall be construed to require a State to join a compact.

(j) State Authority.—A State may not enter into a compact under this subsection unless the State enters into a compact not later than the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(k) Consumer Protections.—If a State enters into a compact it must retain responsibility for the consumer protections of its State, and its residents have the right to bring a claim in a State court in the State in which the resident resides.
Secretary shall determine the total amount that the Secretary will make available for grants under this subsection.

(b) LOANS.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary, not to exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(1) A minimum amount for each State.
(2) An additional amount based on population of the State.

(c) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to the regulation of health insurance coverage sold in its Territory.

(d) RENEWABILITY OF GRANT.—The Secretary may renew a grant award under paragraph (1) if the State retaining the grant agrees to be a member of a compact.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection in each of fiscal years 2015 through 2020.

SEC. 310. HEALTH INSURANCE COOPERATIVES.

(a) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this Act, the Commissioner, in consultation with the Secretary of Health and Human Services, shall establish a Consumer Operated and Oriented Plan exchange program (in this section referred to as the “CO–OP program”) under which the Commissioner may make grants and loans for the establishment and initial operation of not-for-profit, member–run health insurance cooperatives (in this section individually referred to as a “cooperative”) that provide insurance through the Exchange or a State-based Health Insurance Exchange under section 330. Nothing in this section shall be construed as requiring a cooperative to be a not-for-profit, member–run health insurance cooperative.

(b) START–UP AND SOLVENCY GRANTS AND LOANS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(c) GOVERNANCE AND OPERATIONS.—

(B) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(d) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(e) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(f) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(g) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(h) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(i) GOVERNANCE AND OPERATIONS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make:

(A) grants to cooperatives to assist such cooperatives with start-up costs; and
(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) AMOUNT SPECIFIED.—Nothing in this subsection shall be construed to prevent a cooperative from being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

SEC. 311. RETENTION OF DOD AND VA AUTHORITY.

Nothing in this subtitle shall be construed as affecting any authority under title 38, United States Code, or chapter 55 of title 10, United States Code.

Subtitle B—Public Health Insurance Option

SEC. 321. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE–QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with 2011, the Secretary of Health and Human Services, acting through the ‘‘Secretary’’ (hereafter referred to as the ‘‘Secretary’’) shall provide for the offering of an Exchange–participating health benefits plan (in this division referred to as the ‘‘public health insurance option’’) that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle.

(b) OFFERING AS AN EXCHANGE–PARTICI-

PATING HEALTH BENEFITS PLAN.—

(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) ENSURING A LEVEL PLAYING FIELD.—Con-

sideration with this subtitle, the public health insurance option shall comply with require-

ments that are applicable under this title to an Exchange–participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost–sharing.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions, including functions under subsection (a)(4) of section 1874A of the Social Security Act with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMNIBUS.—The Secretary shall estab-

lish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1870A(2) of the Social Security Act.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to es-

tain the public health insurance option for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care in a manner consistent with author-

izing the Secretary (or any employee or contractor) to create or maintain lists of non–medical personal property.

(f) TREATMENT OF PUBLIC HEALTH INSUR-

ANCE OPTION.—With respect to the public health insurance option, the Secretary shall be treated as a QHBP offering entity offering an Exchange–participating health benefits plan.

(g) ACCESS TO FEDERAL COURTS.—The pro-

visions of Medicare (as defined in title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner and as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 322. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

(1) IN GENERAL.—The Secretary shall estab-

lish geographically adjusted premium rates for the public health insurance option—
(A) in a manner that complies with the premium rules established by the Commissi-

on under section 213 for Exchange-part-

icipating health benefits plans; and

(B) at or above levels sufficient to fully finance the costs of—

(1) health benefits provided by the public health insurance option; and

(2) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secre-

tary shall apply an appropriate actuarial reserve for a contingency margin (which shall be not less than 90 days of estimated claims). Before setting any reserve amount for years starting with Y3, the Secretary shall solicit a recommendation on such amount from the American Academy of Actuaries.

(b) PAYMENT RATES FOR ITEMS AND SERVICES.—

(1) ESTABLISHMENT OF A PROVIDER NETWORK.—

(A) IN GENERAL.—Health care providers (including physicians and hospitals) participat-

ing in the Medicare program who receive Medicare payments for services under this section shall be included in the public health insurance option.

(B) ACCOUNT.—

(i) health care providers (other than physicians) or other basis specified by the Secretary) of

(ii) health care providers (other than physicians) under the public health insurance option;

(C) The Secretary shall include information on how providers participating in Medicare who chose to opt out of participating in the public health insurance option may opt back in;

(D) there shall be an annual enrollment pe-

(D) there shall be an annual enrollment pe-

riod in which providers may decide whether to participate in the public health insurance op-

tion.

(3) RULEMAKING.—Not later than 18 months before the first day of Y1, the Secretary shall promulgate rules (pursuant to notice and comment for the process described in para-

graph (1).

(b) ACCOUNT.—

(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option, the Secretary, out of any funds in the Treas-

ury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there are hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropri-

ated, such sums as necessary to cover 90 days of reserve funds based on projected enrollment.

(2) START-UP FUNDING.—

(A) IN GENERAL.—In order to provide for the start-up funding under paragraph (2), Section 1814(g) of the Social Security Act shall apply to the Secretary, in the previous sentence in the same manner as such section ap-

plies to payments or premiums described in such section.

(3) AMORTIZATION OF START-UP FUNDING.—

The Secretary shall provide for the repay-

ment of the start-up funding provided under subparagraph (A) to the Treasury in an am-

ortized manner over the 10-year period begin-

ning with Y1.

(1) LIMITATION ON FUNDING.—Nothing in this section shall be construed as author-

izing any additional appropriations to the Account, other than such amounts as are otherwise appropriated to that Account, or otherwise to the exchange-participating health benefits plans.

(3) NO BAILOUTS.—In no case shall the pub-

lic health insurance option receive any Fed-

eral funding under the Trou-

bled Assets Relief Program of the Secretary.

(4) TREATMENT OF CERTAIN STATE WAIV-

ERS.—In the case of any State operating a cost-containment waiver for health care pro-

viders in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under such waiver in a manner consistent with the provisions and require-

ments of that waiver.

(a) NEGOTIATION OF PAYMENT RATES.—

(A) IN GENERAL.—The Secretary shall nego-

iate payment for such providers under such waiver in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHP offering enti-

ties for services and health care providers.

(b) MANNER OF NEGOTIATION.—The Secre-

tary shall negotiate such rates in a man-

ner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHP offering enti-

ties for services and health care providers.

(c) INNOVATIVE PAYMENT METHODS.—Noth-

ing in this section shall be construed as preventing the use of innovative payment methods such as those described in section 324 in connection with the negotiation of payments under this subsection.

(d) TREATMENT OF CERTAIN STATE WAIV-

ERS.—In the case of any State operating a cost-containment waiver for health care pro-

viders in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under such waiver in a manner consistent with the provisions and require-

ments of that waiver.

(b) ESTABLISHMENT OF A PROVIDER NET-

WORK.—

(A) IN GENERAL.—Health care providers (including physicians and hospitals) participat-

ing in the public health insurance option receive any Fed-

eral funding under the Trou-

bled Assets Relief Program of the Secretary.

(b) ACCOUNT.—

(A) IN GENERAL.—In order to provide for initial claims reserves before the collection of premiums, there are hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropri-

ated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there are hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropri-

ated, such sums as necessary to cover 90 days of reserve funds based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—

The Secretary shall provide for the repay-

ment of the start-up funding provided under subparagraph (A) to the Treasury in an am-

ortized manner over the 10-year period begin-

ning with Y1.

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as author-

izing any additional appropriations to the Account, other than such amounts as are otherwise appropriated to that Account, or otherwise to the ex-

change-participating health benefits plans.

(D) NO BAILOUTS.—In no case shall the pub-

lic health insurance option receive any Fed-

eral funding under the Trou-

bled Assets Relief Program of the Secretary.

(E) TREATMENT OF CERTAIN STATE WAIV-

ERS.—In the case of any State operating a cost-containment waiver for health care pro-

viders in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under such waiver in a manner consistent with the provisions and require-

ments of that waiver.

(a) NEGOTIATION OF PAYMENT RATES.—

(A) IN GENERAL.—The Secretary shall nego-

iate payment for such providers under such waiver in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHP offering enti-

ties for services and health care providers.

(B) MANNER OF NEGOTIATION.—The Secre-

tary shall negotiate such rates in a man-

ner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHP offering enti-

ties for services and health care providers.

(c) INNOVATIVE PAYMENT METHODS.—Noth-

ing in this section shall be construed as preventing the use of innovative payment methods such as those described in section 324 in connection with the negotiation of payments under this subsection.

(d) TREATMENT OF CERTAIN STATE WAIV-

ERS.—In the case of any State operating a cost-containment waiver for health care pro-

viders in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under such waiver in a manner consistent with the provisions and require-

ments of that waiver.
participation in a Federal health care pro-
gram (as defined in section 1128B(f) of the
Social Security Act).

SEC. 326. APPLICATION OF FRAUD AND ABUSE
PROVISIONS.

Provisions of civil law identified by the
Secretary by regulation, in consultation with the Inspector General of the Depart-
ment of Health and Human Services, that
impose sanctions with respect to waste, fraud, and abuse under Medicare, such as sec-
tions 1128B(f) and 3751 of title 31, United
States Code (commonly known as the False
Claims Act), shall also apply to the public health insurance option.

SEC. 327. APPLYING OF HIPAA INSURANCE
REQUIREMENTS.

The requirements of sections 2701 through
2792 of the Public Health Service Act shall
apply to the public health insurance option
in the same manner as they apply to health
insurance coverage offered by a health insur-
ance issuer in the individual market.

SEC. 328. REIMBURSEMENT OF SSI INFORMA-
TION PRIVACY, SECURITY, AND ELECTRONIC
TRANSACTION REQUIREMENTS.

Part C of title XI of the Social Security Act,
relating to standards for protections against
the wrongful disclosure of individually
identifiable health information, health
information security, and the electronic ex-
change of health care information, shall
apply to the public health insurance option
in the same manner as they apply to other
health plans (as defined in section
1171(i) of such Act).

SEC. 329. ENROLLMENT IN PUBLIC HEALTH IN-
SURANCE OPTION IS VOLUNTARY.

Nothing in this division shall be construed
as requiring anyone to enroll in the public
health insurance option. Enrollment in such
option shall be voluntary.

SEC. 330. ENROLLMENT IN PUBLIC HEALTH IN-
SURANCE OPTION BY MEMBERS OF CONGRESS.

Notwithstanding any other provision of this
Act, Members of Congress may enroll in
the public health insurance option.

SEC. 331. REALM OF AUTHORITY OF SECRETARY OF VETERANS AFFAIRS.

The Secretary of Health and Human Serv-
ces shall seek to enter into a memorandum
of understanding with the Secretary of Vet-
erans Affairs regarding the recovery of costs
related to non-service-connected care or
services provided by the Veterans Affairs
Department to individuals covered under
the public health insurance option in a ma-
nner consistent with recovery of costs related
to non-service-connected care from private
health insurers.

Subtitle C—Individual Affordability Credits

SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) In General.—The following provisions of
this subtitle, in the case of an affordable
credit eligible individual enrolled
in an Exchange-participating health benefits
plan—

(1) the individual shall be eligible for, in
accordance with this subtitle, affordability
credits consisting of—

(A) an affordability premium credit under
section 343 to be applied against the pre-
mium for the Exchange-participating health
benefits plan in which the individual is en-
rolled; and

(B) an affordability cost-sharing credit
under section 344 to be applied as a reduction
of the cost-sharing otherwise applicable to
such plan;

(2) the Commissioner shall pay the QHP
offering entity that offers such plan from the
Health Insurance Exchange Trust Fund
the aggregate affordability credits for
all affordable credit eligible individuals en-
rolled in such plan.

(b) APPLICATION.—

(1) In General.—An Exchange eligible indi-
vidual may apply to the Commissioner
through the Health Insurance Exchange or
the Health Choices Commissioner such an ar-
range ment made with the Commissioner, in a form
and manner specified by the Commissioner.
The Commissioner through the Health Insur-
ance Exchange shall make such an arrange-
ment with such another public en-
tity under an arrangement made with the
Commissioner shall make a determination as to
eligibility of an individual for afford-
bility credits under this title. The Commis-
ioner shall establish a process whereby,
on the basis of information otherwise avail-
able, individuals may be deemed to be afford-
able credit eligible. In carrying out such
process, the Commissioner shall estab-
lish effective methods that ensure that indi-
viduals with limited English proficiency are
able to apply for affordability credits

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner deter-
mines that a State Medicaid agency has the capacity to make a
determination of eligibility for affordability
credits under this subtitle and under the
same standards as used by the Commis-
ioner, under the Medicaid memorandum of
understanding under section 305(e)(2)—
(A) the State Medicaid agency is author-
ized to conduct such determinations for any
Exchange-eligible individual who requests
such a determination; and

(B) the Commissioner shall reimburse the
State Medicaid agency for the costs of con-
ducting such determinations.

(c) VERIFICATION PROCESS FOR CITIZENS.

(1) In General.—In the case of an individual
making the declaration described in
subparagraph (B)(i) subject to clause (ii), the verification procedures of paragraphs
(2) through (5) of section 1137(d) of the Social
Security Act shall apply to such declaration
described in such subparagraph; and

(2) the verification process shall apply
to a declaration described in paragraph (1) of
such section.

(3) Special Rules.—In applying such para-
graphs of section 1137(d) of such Act
under clause (i)—

(I) any reference in such paragraphs to a
State is deemed a reference to the Health
Choices Commissioner; and

(II) any reference to benefits under a
program is deemed a reference to affordability
credits under this subtitle.

(d) APPLICATION OF STATE-BASED EX-
CHANGES.—In the case of the application
of the verification process under this subpara-
graph, the Health Choices Commissioner
shall apply the verification procedures of
paragraphs (2) through (5) of section 1137(d) of the Social
Security Act to such application as if the verification
process would apply to a declaration described in paragraph (1) of
such section.

(2) Special Rules.—In applying such para-
graphs of section 1137(d) of such Act
under clause (i)—

(I) any reference in such paragraphs to a
State is deemed a reference to the Health
Choices Commissioner; and

(II) any reference to benefits under a
program is deemed a reference to affordability
credits under this subtitle.

(e) Annual Reports.—The Health Choices
Commissioner shall report to Congress an-
ually on the number of applicants for afford-
ability credits under this subtitle, their citi-
zension or immigration status, and the dis-
position of their applications. Such report
shall be made publicly available and shall in-
clude information on—

(1) the number of applicants whose declara-
tion of citizenship or immigration status,
name, or social security account number was
not consistent with records maintained by
the Commissioner of Social Security or the
Department of Homeland Security and, of
such applicants, the number who contested
the inconsistency and sought to document
their citizenship or immigration status,
name, or social security account number or
correct the information maintained in such
records and, of those, the results of
such contests; and

(2) the administrative costs of conducting
the status verification under this paragraph.

(f) Repeal.—The rules of section 206 of
Title II of the Affordable Care Act as
amended by section 206 of Title II of
the Patient Protection and Affordable Care
Act shall apply to such declaration in the same
manner as such section applies to a declara-
tion described in paragraph (1) of such sec-
tion.
Ways and Means, the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on the Judiciary of the House of Representatives and the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on the Judiciary of the Senate a report examining the effectiveness of the citizenship and immigration verification systems applied under this paragraph. Such report shall include an analysis of the following:

(i) The causes of erroneous determinations under such systems.

(ii) The effectiveness of the processes used in removing erroneous determinations.

(iii) The impact of such systems on individuals, health care providers, and Federal and State agencies, including the effect of erroneous determinations under such systems.

(iv) The effectiveness of such systems in preventing ineligible individuals from receiving for affordability credits.

(v) The characteristics of applicants described in subparagraph (E)(i).

(G) PROHIBITION OF DATABASE.—Nothing in this paragraph or section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new paragraph:

(6)(A) With respect to the use by any contractor of the Health Choices Commissioner under such paragraph (4), the Commissioner of Social Security and the Health Choices Commissioner shall coordinate the information required to be collected by the Health Choices Commissioner under such paragraph (4) with the information provided by the Commissioner of Social Security consistent with section 341(b)(v) of Affordable Health Care for America Act.

(6)(B) Information provided by the Commissioner of Social Security consistent with section 341(b)(v) of Affordable Health Care for America Act shall be treated as information required to be collected by the Health Choices Commissioner under such paragraph (4).

(H) INITIAL FUNDING.—

(i) For any fiscal year in which the Social Security Administration and Health Care for America Act is amended by section 205(v)(2) of the Social Security Act, the Social Security Administration and Health Care for America Act shall provide for funding to the Commissioner of Social Security in accord-
(i) information about the reason for such notice;

(ii) a description of the right of the recipient of the notice under subparagraph (A)(i) to contest the right to access to records of the Department of Homeland Security that is reasonable for purposes of this title, subject to paragraph (3) and section 546, to be used for enrollment in a basic plan.

(iii) a description of the right of the recipient under subparagraph (A)(i) to access and attempt to amend, correct, and update the individually identifiable information contained within records of the system described in paragraph (3); and

(iv) instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies.”.

(C) STREAMLINING ADMINISTRATION OF VERIFICATION PROCESSES FOR UNITED STATES CITIZENS.—Section 1902(ee)(2) of the Social Security Act (42 U.S.C. 1396a(ee)(2)) is amended by adding at the end the following:

“(D) In carrying out the verification procedures under this subsection with respect to a State, if the Commissioner of Social Security determines that the records maintained by such Commissioner are not consistent with an individual’s alleged status as a United States citizen, pursuant to procedures which shall be established by the State in coordination with the Commissioner of Social Security, the Secretary of Homeland Security, and the Secretary of Health and Human Services—

“(i) the Commissioner of Social Security shall inform the State of the inconsistency; and

“(ii) upon being so informed of the inconsistency, the State shall submit the information on the individual to the Secretary of Homeland Security for a determination of whether the records of the Department of Homeland Security indicate that the individual is a citizen.

“(iii) upon making such determination, the Department of Homeland Security shall inform the State of the determination; and

“(iv) if such determination provided by the Commissioner of Social Security shall be considered as strictly confidential and shall only be used by the State and the Secretary of Homeland Security for the purposes of such verification procedures.

“(E) Verification of status eligibility pursuant to the procedures established under this subsection is a verification of status eligibility for purposes of this title, title XXI, and affordability credits under section 343, but not the affordability cost-sharing credits for emergency and disaster declared under section 59B of the Internal Revenue Code of 1986 as such information may be required to carry out this subtitle.

“(F) No Cash Rebates.—In no case shall an affordable credit eligible individual receive any cash payment as a result of the application of this subtitle.

SEC. 342. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term ‘affordable credit eligible individual’ means, subject to subsection (b) and section 346, an individual who is lawfully present in a State in the United States other than as a nonimmigrant described in subparagraph (B) of section 101(a)(15) of the Immigration and Nationality Act—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health plan that meets the requirements of section 412;

(B) with modified adjusted gross income below 400 percent of the Federal poverty level for a family of the size involved;

(C) who is a Medicaid eligible individual, other than an individual described in section 546, to be used for enrollment in an Exchange-participating health benefits plan.

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of the same family who are affordable credit eligible individuals shall be treated as a single affordable credit eligible individual eligible for the applicable credit for such a family under this subtitle.

(3) SPECIAL RULE FOR INDIANS.—Subparagraph (D) of paragraph (1) shall not apply to an individual who has coverage that is treated as a brand-name prescription drug coverage for purposes of section 59B(d)(2) of the Internal Revenue Code of 1986 but is not treated as acceptable coverage for purposes of this division.

(b) AFFORDABLE PREMIUM AMOUNT.—

(1) IN GENERAL.—The affordable premium amount specified in this subsection for an individual for the plan year shall be equal to the product of—

(A) the premium percentage limit specified in paragraph (2) for the individual based upon modified adjusted gross income for the plan year; and

(B) the individual’s modified adjusted gross income for such plan year.

(2) PREMIUM PERCENTAGE LIMITS BASED ON TABLE.—The Commissioner shall establish premium percentage limits so that for individuals whose modified adjusted gross income is within an income tier specified in the table in subsection (d) such percentage limits shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final percentage specified in such table for such income tier.

(c) REFERENCE PREMIUM AMOUNT.—The reference premium amount specified in this subsection for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium levels. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) TABLE OF PREMIUM PERCENTAGE LIMITS, ACTUARIAL VALUE PERCENTAGES, AND OUT-OF-POCKET LIMITS FOR Y1 BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subsection, subject to paragraph (3) and section 346, the table specified in this subsection is as follows:

In the case of modified adjusted gross income (expressed as a percent of FPL) within the following income tier:

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Initial premium percentage limit</th>
<th>Final premium percentage limit</th>
<th>Actuarial value percentage limit</th>
<th>Out-of-pocket limit for 1 in 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>133% through 150%</td>
<td>1.5%</td>
<td>3.0%</td>
<td>97%</td>
<td>$2,000</td>
</tr>
<tr>
<td>150% through 175%</td>
<td>3.0%</td>
<td>5.5%</td>
<td>85%</td>
<td>$2,000</td>
</tr>
<tr>
<td>175% through 200%</td>
<td>5.5%</td>
<td>8.0%</td>
<td>72%</td>
<td>$1,000</td>
</tr>
<tr>
<td>200% through 225%</td>
<td>8.0%</td>
<td>10.0%</td>
<td>70%</td>
<td>$1,000</td>
</tr>
<tr>
<td>225% through 250%</td>
<td>10.0%</td>
<td>11.0%</td>
<td>70%</td>
<td>$1,000</td>
</tr>
<tr>
<td>250% through 275%</td>
<td>11.0%</td>
<td>12.0%</td>
<td>70%</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
(2) SPECIAL RULES.—For purposes of applying the table under paragraph (1):

(A) FOR LOWEST LEVEL OF INCOME.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133 percent of FPL.

(B) APPLICATION OF HIGHER ACTUARIAL VALUE POINTS.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133 percent of FPL.

Sec. 344. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) (2) (B) for family coverage is twice the maximum actuarial value percentage (specified in the table under section 343(d) for the income tier involved) of the full actuarial value that would be required to impose a level of governmental to enrollee shares of premiums over time, for each income tier identified in the table in paragraph (1).

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing amounts for an individual under section 343(d) for each income tier specified in the table under section 343(d), with respect to a year, in a manner so that, as estimated by the Commissioner—

(1) the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual limitation on cost-sharing amounts) is equal to the actuarial value percentage (specified in the table under section 343(d) for the income tier involved) of the full actuarial value that would be required if no cost-sharing imposed under the plan; and

(2) the annual limitation on cost-sharing specified in section 343(c)(2)(B) is reduced to a level that does not exceed the annual limitation on cost-sharing otherwise applicable.

(c) MAXIMUM OUT-OF-POCKET LIMIT.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum out-of-pocket limit specified in this subsection for an individual with income under subsection (a) is—

(A) for individual coverage—

(i) for Y1 is the out-of-pocket limit for Y1 specified in subsection (c) in the table under section 343(d) for the income tier involved for a plan year is expected (in a manner significant change, the verifiable information so disclosed to verify such information provided so that such information is made available to the Commissioner and requiring the substitution of such income for the income other circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

Sec. 345. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be determined before Y1 by the Secretary under section 342(c)(6) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty line shall be increased (rounded to the nearest whole number) to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y1, the Secretary shall submit to Congress a report on such study and include such recommendations as the Secretary determines appropriate.

(b) PROGRAM INTEGRITY.—

(1) PROOF OF INCOME.—The Commissioner shall take such steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 342(b)) or upon a application for a change in the affordability credit based upon a significant change in modified adjusted gross income described in subsection (c)(1)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be required to be contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(2) SPECIAL RULES.—

(A) CHANGES IN INCOME AS A PERCENT OF FPL.—For purposes of this subtitle if income tax return is available is significant different from the income (as so expressed) used under subsection (a), the Commissioner shall establish rules requiring an individual to report, consistent with the mechanism established under paragraph (2), significant changes in such income (including a significant change in family composition) to the Commissioner and requiring the substitution of such income for the income otherwise applicable.

(B) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner within 30 days if the modified adjusted gross income of the individual (expressed as a percentage of the Federal poverty level for a family of the size involved) for a plan year is expected (in a manner otherwise applicable.

(c) MAXIMUM OUT-OF-POCKET LIMIT.—

(1) IN GENERAL.—subject to paragraph (2), the maximum out-of-pocket limit specified in this subsection for an individual with income under subsection (a) is—

(A) for individual coverage—

(i) for Y1 is the out-of-pocket limit for Y1 specified in subsection (c) in the table under section 343(d) for the income tier involved for a plan year is expected (in a manner significant change, the verifiable information so disclosed to verify such information provided so that such information is made available to the Commissioner and requiring the substitution of such income for the income other circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 342(b)) or upon an application for a change in the affordability credit based upon a significant change in modified adjusted gross income described in subsection (c)(1)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be required to be contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(2) SPECIAL RULES.—

(A) IN GENERAL.—TheSecretary should ensure that the study under subparagraph (A) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

(ii) TERRITORIES DEFINED.—In this subparagraph, the term ‘‘territories of the United States’’ includes the Commonwealth of Puerto Rico, the United States territories, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.

(d) PENALTIES FOR MISREPRESENTATION.—In the case of an individual who intentionally misrepresents modified adjusted gross income otherwise applicable.

(2) IN THE CASE OF SUCH AN INTENTIONAL MISREPRESENTATION OR OTHER EGREGIOUS CIRCUMSTANCES SPECIFIED BY THE COMMISSIONER, THE COMMISSIONER MAY IMPOSE AN ADDITIONAL PENALTY.

Sec. 346. SPECIAL RULES FOR APPLICATION TO TERRITORIES.

(a) ONE-TIME ELECTION FOR TREATMENT AND APPLICATION OF FUNDING.—

(A) IN GENERAL.—A territory may elect, in a form and manner specified by the Commissioner, to apply the provisions of title XXI of the Social Security Act to the territory as applied by the Secretary of Health and Human Services and the Secretary of the Treasury and not later than October 1, 2012, either—

(B) to be treated as a State for purposes of applying this title and title II; or

(2) not to be so treated but instead, to have the dollar limitation otherwise applicable.

(2) CONDITIONS FOR ACCEPTANCE.—The Commissioner has the nonreviewable authority to accept or reject an election described in paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in subsection (b) between the Commissioner and the territory and subsection (c); and

(B) subject to the approval of the Secretary of Health and Human Services and the Secretary of the Treasury and subject to such other terms and conditions as the Commissioner, in consultation with such Secretary, may specify.

(3) DEFAULT RULE.—A territory failing to make such an election (or having an election
under paragraph (1)(A) not accepted under paragraph (2) shall be treated as having made the election described in paragraph (1)(B).

(b) AGREEMENT FOR SUBSTITUTION OF PERCENTAGES FOR AFFORDABILITY CREDITS.—

(1) NEGOTIATION.—In the case of a territory making an election under paragraph (a)(1)(A) (in this section referred to as an “electing territory”), the Commissioner, in consultation with the Secretaries of Health and Human Services and the Treasury, shall enter into negotiations with the government of such territory so that, before Y1, there is an agreement reached between the parties on the percentages that shall be applied under paragraph (2) for that territory. The Commissioner shall not enter into such an agreement unless—

(A) payments made under this subtitle with respect to residents of the territory are consistent with the cap established under subsection (c) for such territory and with subsection (d); and

(B) the requirements of paragraphs (3) and (4) are met.

(2) APPLICATION OF SUBSTITUTE PERCENTAGES AND DOLLAR AMOUNTS.—In the case of an electing territory, there shall be substituted in section 32(a)(1)(B) and in the table in section 342(a)(1)(C) for 400 percent, 153 percent, and other percentages and dollar amounts specified in such table, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:

(A) NO INCOME GAP BETWEEN MEDICAID AND AFFORDABILITY CREDITS.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between income levels at which medical assistance is available through Medicaid and the income level at which affordability credits are available.

(B) ADJUSTMENT FOR OUT-OF-POCKET RESPONSIBILITY FOR PREMIUMS AND COST-SHARING IN RELATION TO INCOME.—The substituted percentages of FPL for income tiers under such table shall be specified in a manner so as to prevent any gap in coverage for individuals between income level at which medical assistance is available through Medicaid and the income level at which affordability credits are available.

(C) OPTIONAL SUPPLEMENTATION FOR PUERTO RICO.—

(i) IN GENERAL.—Puerto Rico may elect, in a form specified by the Secretary of Health and Human Services in consultation with the Commissioner to increase the dollar amount specified in subparagraph (A) by up to $1,000,000,000.

(ii) OFFSET IN MEDICAID CAP.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease the dollar limitation otherwise applicable to Puerto Rico under subsections (f) and (g) of section 1106 of the Social Security Act (42 U.S.C. 1306) for a fiscal year by the additional amount specified in this paragraph.

(iii) LIMITATION ON FUNDING.—In no case shall this section (including the agreement under subsection (b)) permit—

(A) the obligation of funds for expenditures under this subtitle for periods beginning on or after January 1, 2020; or

(B) any increase in the dollar limitation described in subsection (a)(1)(B) for any portion of any fiscal year occurring on or after such date.

SEC. 347. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this Act shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States.

TITLE IV—SHARED RESPONSIBILITY

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 401. INDIVIDUAL RESPONSIBILITY.

For an individual’s responsibility to obtain acceptable coverage, see section 59B of the Internal Revenue Code of 1986 (as added by section 501 of this Act).

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 411. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

An employer meets the requirements of this section if such employer does all of the following:

(1) OFFER OF COVERAGE.—The employer offers to its full-time employees, and, if any, the employee’s spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986), an Exchange-participating health benefits plan or other than employment-based health plan (other than a high deductible health plan) during the calendar year in which such offer is made.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 412.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2 if the employer declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by employment-based health plan (other than a high deductible health plan) of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 413.

SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARD EMPLOYEE AND DEPENDENT COVERAGE.

(a) IN GENERAL.—An employer meets the requirements of this section with respect to an employee if the following requirements are met:

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 411(1). In the case of an Exchange-eligible employer, the employer may offer such coverage either through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer’s contribution toward the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

(b) PROVISION OR EXTENSION OF COVERAGE.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section, including the following:

(A) The name, date, and employer identification number of the employer.

(B) A certification as to whether the employer offers coverage to its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a current employment-based health plan (within the meaning of section 202(b)).

(C) If the employer certifies that the employee did offer to its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a current employment-based health plan (within the meaning of section 202(b)),

(i) the months during the calendar year for which such coverage was available; and

(ii) the monthly premium for the lowest cost plan offered to each such category under each such plan offered to employees.

(D) The name, address, and NIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such plans.

(E) AUTORENROLLMENT OF EMPLOYEES.—The employer provides for autoenrollment of the employee in accordance with subsection (c).

(1) AUTORENROLLMENT.—An employer described in section 411(1) of the Internal Revenue Code of 1986 (as added by section 501 of this Act)

(2) EXTENSION.—Beginning with Y2, the employer provides for autoenrollment of the employee described in section 411(1) of the Internal Revenue Code of 1986 (as added by section 501 of this Act) in the coverage described in section 411(1).

(3) AUTORENROLLMENT.—Beginning with Y2, the employer provides for autoenrollment of the employee described in section 411(1) of the Internal Revenue Code of 1986 (as added by section 501 of this Act) in the coverage described in section 411(1).
qualified health benefits plan (or is such current employment-based health plan); and

(B) in the case of family coverage which includes coverage of such spouse and children, not less than $750,000 of such applicable premium of such lowest cost plan.

2. APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 412(b)(1) with respect to a full-time employee that reflects the proportion of:

(A) the average weekly hours of employment, by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

3. MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYERS OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution requirement if the Secretary determines that such proportion reflects the proportion of:

(A) the average weekly hours of employment, by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

4. EMPLOYER RESPONSIBILITY REQUIREMENTS.—For purposes of this section, any contribution on behalf of an employee that reflects the proportion of:

(A) the average weekly hours of employment, by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee

shall conduct a study to examine the effect of this section referred to collectively as "employer responsibility requirements" on employer-based health plan sponsorship, generally and within specific industries, and the effect of such requirements and thresholds on employers, employment-based health plans, and employees in each industry.

5. ANNUAL REPORT.—The Secretary of Labor shall conduct a report on findings on how employer responsibility requirements have impacted and are likely to impact employers, plans, and employees during the previous year and projected trends.

6. LEGISLATIVE RECOMMENDATIONS.—No later than January 1, 2012 and on an annual basis thereafter, the Secretary of Labor shall submit legislative recommendations to Congress to modify the employer responsibility requirement if the Secretary determines that the requirements are determentially affecting or will detrimentally affect employer plan sponsorship or otherwise creating inequities among employers, health plans, and employees. The Secretary may also submit such recommendations as the Secretary deems necessary to improve and strengthen employment-based health plan sponsor-ship, employer responsibility, and related proposals that would enhance the delivery of health care benefits between employers and employees.

SEC. 416. STUDY ON EMPLOYER HARDSHIP EXPECTATION.

(a) IN GENERAL.—The Secretary of Labor shall conduct a study to examine the effect of the employer responsibility requirements if the Secretary determines that the requirements are determentially affecting or will detrimentally affect employer plan sponsorship or otherwise creating inequities among employers, health plans, and employees. The Secretary may also submit such recommendations as the Secretary deems necessary to improve and strengthen employment-based health plan sponsor-ship, employer responsibility, and related proposals that would enhance the delivery of health care benefits between employers and employees.

(b) REPORT.—Not later than January 1, 2012, the Secretary shall submit to Congress a report on findings and make a recommendation to Congress about whether an employer hardship exemption would be appropriate.

7. EMPLOYER RESPONSIBILITY REQUIREMENTS.—For purposes of this section, any contribution on behalf of an employee that reflects the proportion of:

(A) the average weekly hours of employment, by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.
"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS"

"SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) In General.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

(b) Time and Manner.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

"SEC. 802. TREATMENT OF COVERED RESULTING FROM ELECTION.

(a) In General.—An employer who makes an election under this section 801—

(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 729(a) for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

(b) Periodic Investigations to Discover Noncompliance.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 803 to such extent as is necessary to ensure that such plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall thereafter, to such extent as is necessary, take such timely enforcement action as appropriate to achieve compliance.

(c) Recordkeeping.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The Secretary shall promulgate such recordkeeping requirements shall be determined by the Secretary and shall be designed to ensure that employers who are not properly treated as such may be identified and properly treated.

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of title II of division A of (as in effect on the date of the enactment of such Act).

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

(a) Affiliated Groups.—In the case of any employer who is a part of a group of employers who are treated as a single employer under subsection (b), (c), (m), (o) or (s) of section 414 of the Internal Revenue Code of 1986, the election of the Secretary shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

(b) Separate Elections.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

(1) different lines of business, and

(2) full-time employees and employees who are not full-time employees.

"SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.

The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements. The Secretary may refer any such determination to the Secretary of the Treasury as appropriate.

"SEC. 806. REGULATIONS.

"Sec. 806. Regulations.

"Sec. 805. Termination of election in cases of substantial noncompliance.

"(a) ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"Sec. 801. Election of employer to be subject to national health coverage participation requirements.

"Sec. 802. Treatment of coverage resulting from election.

"Sec. 803. Health coverage participation requirements.

"Sec. 804. Rules for applying requirements.

"Sec. 805. Termination of election in cases of substantial noncompliance.

"Sec. 806. Regulations.

"(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.
TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) In General.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART VIII—HEALTH CARE RELATED TAXES"

"SUBPART A—TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

"(a) Tax Imposed.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the difference between:

(i) the modified adjusted gross income for the taxable year, over

(ii) the amount of gross income specified in section 602(a)(1) with respect to the taxpayer.

"(b) Limitations.—

"(1) Tax Limited to Average Premium.—

"(A) In General.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

"(B) Applicable National Average Premium.—

"(i) In General.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary of the Treasury in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

"(ii) Failure to Provide Coverage for More Than One Individual.—In the case of a taxpayer who fails to meet the requirements of subsection (d) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

"(2) Proration for Part Year Failures.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as the number of full months during which the tax imposed under subsection (a) applies to the taxpayer bears to 12 months.

"(3) Exception.—

"(A) The aggregate periods during which such taxable year for which such individual failed to meet the requirements of subsection (d), shall be treated as 1 full taxable year for purposes of applying the provisions of this section.

"(B) The entire taxable year.

"(c) Exceptions.—"
(1) Dependents.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for the same taxable year beginning in the same calendar year as such taxable year.

(2) Nonresident aliens.—Subsection (a) shall not apply to any individual who is a nonresident alien.

(3) Individuals residing outside United States.—Any qualified individual (as defined in section 931(d)) and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) of (2) section 931(d) if applicable.

(4) Individuals residing in possessions of the United States.—Any individual who is bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

(5) Religious conscience exemption.—

(A) In general.—Subsection (a) shall not apply to any individual and any qualifying child residing with such individual for any period if such individual has in effect an exemption which certifies that such individual is a member of a sect or religious denomination whose teachings require such individual to be covered by acceptable coverage during such period.

(B) Application.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such manner as the Secretary may prescribe. The Secretary may treat an application for exemption under section 1402(g)(1) as an application for exemption under section (a) of this subsection, or may otherwise coordinate applications under such sections, as the Secretary determines appropriate. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

(d) Acceptable coverage requirement.

(1) In general.—The requirements of this subsection are met with respect to any individual obtaining coverage under the Affordable Health Care for America Act, including similar coverage furnished under chapter 55 of title 10, United States Code, including coverage furnished under section 1781 of title 38 of such Code.

(2) Members of Indian tribes.—Health care services made available through the Indian Health Service, a tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), and an Indian organization (as defined in such section) to members of an Indian tribe (as defined in such section).

(3) Members of Armed Forces and Dependents.—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under title XIX of the Social Security Act.

(4) Members of Indian tribes.—Health care services made available through the Indian Health Service, a tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), and an Indian organization (as defined in such section) to members of an Indian tribe (as defined in such section).

(5) Covered.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

(6) Other definitions and special rules.

(1) Qualifying child.—For purposes of this section, the term ‘qualifying child’ has the meaning given such term by section 152(c).

(2) Basic plan.—For purposes of this section, the term ‘basic plan’ has the meaning given such term by section 100(c) of the Affordable Health Care for America Act.

(3) Insurance exchange.—For purposes of this section, the term ‘Health Insurance Exchange’ has the meaning given such term by section 100 of chapter 17 of title 26, United States Code, including similar coverage furnished under chapter 55 of title 10, United States Code.

(4) Community.—For purposes of this section, the term ‘family coverage’ means any coverage other than self-only coverage.

(5) Modified adjusted gross income.—For purposes of this section, the term modified adjusted gross income means adjusted gross income computed without regard to—

(A) any amount excluded from gross income under section 911, and

(B) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(6) Not treated as tax imposed by this chapter for certain purposes.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 59B.

(d) Return requirement.—Subsection (a) of section 6052 of such Code is amended by inserting ‘(c)’ at the end of clause (xxxii), by striking ‘and’ and inserting ‘or’ in clause (xxxi), and by striking ‘or’ at the end of clause (xxxii).

(e) Other definitions and special rules.—

(1) Regulations.—The Secretary shall prescribe such regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

(a) exemption from the tax imposed under subsection (a) in cases of hardship, including a process for applying for such a waiver.

(b) Information reporting.—

(1) In general.—Subpart B of part III of chapter 61 of title 26 is amended by inserting after section 6050W the following new section:

SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

(a) Requirement of reporting.—Every person who provides acceptable coverage (as defined in section 59B) to any eligible individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

(b) Form and manner of returns.—A return is described in this subsection if such return—

(1) in such form as the Secretary may prescribe, and

(2) contains—

(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy or plan,

(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

(C) such other information as the Secretary may require.

(c) Statements to be furnished to individuals with respect to whom information required.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

(i) the name and address of the person required to make such return and the phone number of the information contact for such person, and

(ii) the information required to be shown on the return with respect to such individual.

(4) Penalty for failure to file.—

(A) Return.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking ‘or’ at the end of clause (xxii), by striking ‘and’ and inserting ‘or’ in clause (xxxi) and inserting ‘and’ and by adding at the end the following new clause:

‘(xxxi) section 6050X (relating to returns relating to health insurance coverage), and’

(B) Statement.—Subsection (A) of section 6052A of such Code is amended by inserting ‘or’ at the end of subparagraph (EE), by striking the period at the end of subparagraph (EE) and by inserting after paragraph (FF) the following new subparagraph:

‘(GG) section 6050X (relating to returns relating to health insurance coverage), and’

(c) Return requirement.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

‘(10) Every individual to whom section 59B applies and who fails to meet the requirements of section 59B with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.

(d) Clerical amendments.—

(1) The table of parts for chapter 1 of the Internal Revenue Code of 1986 is amended by adding the following new item:

‘PART VIII. HEALTH CARE RELATED TAXES.’

(2) The table of sections for chapter 19 of the Internal Revenue Code of 1986 is amended by adding the following new item:

‘Sec. 6050X. Returns relating to health insurance coverage.’

(e) Section 15 not to apply.—The amendment made by subsection (a) shall not be applied to a calendar year after the taxable year beginning after December 31, 2012.
(2) RETURNS.—The amendments made by subsection (b) shall apply to calendar years beginning after December 31, 2012.

Subpart B—Employer Responsibility

SEC. 511. ELECTION TO SATISFY HEALTH COVERAGE PARTICIPATION REQUIREMENTS

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

``SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

''(1) IN GENERAL.—Subsection (b) shall apply with respect to an employer for any period with respect to which an election under subsection (a) is in effect to satisfy the health coverage participation requirements with respect to any employees of such employer who make such election applies, there is hereby imposed on such each such employee a tax of $100 for each month in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF TAX.—

''(A) TAX NOT TO APPLY TO FAILURES NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence, would have known, that such failure existed.

''(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

''(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—For purposes of this paragraph, the term 'annual payroll' means—

''(i) $500,000.

''(ii) $465,000.

''(iii) $420,000.

''(iv) $375,000.

''(v) $330,000.

''(vi) $285,000.

''(vii) $240,000.

''(viii) $195,000.

''(ix) $150,000.

''(10) $105,000.

''(11) $60,000.

''(12) $15,000.

''(13) $0.

(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

''(1) separate lines of business, and

''(2) full-time employees and employees who are not full-time employees.

''(3) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

If the annual payroll of such employer for the preceding calendar year is

Does not exceed $500,000 ........................................................................................................................................................................ 6 percent

Exceeds $465,000, but does not exceed $585,000 ......................................................................................................................... 2 percent

Exceeds $585,000, but does not exceed $750,000 ......................................................................................................................... 4 percent

Exceeds $750,000, but does not exceed $1,000,000 ......................................................................................................................... 6 percent

(B) SMALL EMPLOYER.—For purposes of this section, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $50,000.

(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3401(w)) paid by him with respect to any employee to whom such election applies, there is hereby imposed on such each such employee a tax of $100 for each month in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 4980B(a) of the Public Health Service Act with respect to such failure.

(E) 'HEALTH COVERAGE PARTICIPATION REQUIREMENTS.'—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part I of subtitle B of title IV of the (as in effect on the date of the enactment of this section).

(f) APPLICATION TO RAILROADS.—In the case of any employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

(g) COORDINATION; PREDECESSORS.—For purposes of section 4980H(a) for any period with respect to which such employer does not have an election under section 4980H(a) (as in effect on the date of the enactment of this section), is amended by striking "a tax of $100 for each month in the period beginning on the date such failure first occurs and ending on the date such failure is corrected."

(h) FORMS AND REPORTING.—In the case of any employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the compensation paid during any calendar year for employment-related health benefits.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 512. HEALTH CARE CONTRIBUTIONS OF NONSELECTING EMPLOYERS

(a) IN GENERAL.—Section 3111 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

``(c) EMPLOYERS SELECTING NOT TO PROVIDE HEALTH BENEFITS.—In the case of any employer who is in substantial noncompliance with the health coverage participation requirements with respect to which the election under subsection (b) is in effect, the term 'annual payroll' means—

''(i) $500,000.

''(ii) $465,000.

''(iii) $420,000.

''(iv) $375,000.

''(v) $330,000.

''(vi) $285,000.

''(vii) $240,000.

''(viii) $195,000.

''(ix) $150,000.

''(10) $105,000.

''(11) $60,000.

(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

''(A) IN GENERAL.—In the case of any employer who is small employer for any calendar year, paragraph (1) shall be applied by substituting the applicable percentage determined in accordance with the following table for '6 percent':

The applicable percent- age is:

0 percent........................................................................................................................................................................ 4 percent

6 percent........................................................................................................................................................................ 8 percent

(B) SMALL EMPLOYER.—For purposes of this subsection, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $50,000.

(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3401(w)) paid by him with respect to any employee to whom such election applies, there is hereby imposed on such each such employee a tax of $100 for each month in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 4980B(a) of the Public Health Service Act with respect to such failure.

(E) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 513. EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS

(a) IN GENERAL.—Section 3221 of such Code is amended by adding at the end the following new subsection:

``(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of any employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the compensation paid during any calendar year for employment-related health benefits.

''(2) EXCEPTION FOR SMALL EMPLOYERS.—

''(A) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonselecting employer an excise tax, with respect to having individuals in his employ, equal to 4 percent of the wages (as defined in section 3121(a) paid by him with respect to employment (as defined in section 3121(b)).

''(B) SPECIAL RULES FOR SMALL EMPLOYERS.—

''(A) IN GENERAL.—In the case of any employer who is small employer for any calendar year, paragraph (1) shall be applied by substituting the applicable percentage determined in accordance with the following table for '8 percent':

The applicable percent- age is:

0 percent........................................................................................................................................................................ 4 percent

6 percent........................................................................................................................................................................ 8 percent

(B) SMALL EMPLOYER.—For purposes of this subsection, the term 'small employer' means any employer for any period with respect to which such employer does not have an election under section 4980H(a) (as in effect on the date of the enactment of this section).

(C) EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—

(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonselecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year for employment-related health benefits.

(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

Rules similar to the rules of section 3111(c)(2) shall apply for purposes of this subsection.

(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term 'nonelecting employer' means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of any employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the compensation paid to employees who are not subject to such election.

(5) DEFINITIONS.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:
"(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 322(c)—
(A) Paragraph (1) shall be applied without regard to the first sentence thereof.
(B) Paragraph (2) shall not apply."

(3) CONFORMING AMENDMENT.—Subsection (d) of section 322 of such Code, as redesignated by section 2(a) of such Act, is amended by adding the following new section:

SEC. 43R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

"SEC. 43R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

(a) IN GENERAL.—For purposes of section 38, in the case of an employer who employs more than 10 qualified employees during the taxable year, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(b) APPLICABLE PERCENTAGE.—
(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under this section for such taxable year is an amount equal to the product of—

(A) the average annual employee compensation of such employer for such taxable year

and

(B) the applicable percentage.

(c) LIMITATIONS.—
(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under this section shall be reduced by the amount of the credit determined under this section for any employer who employs 10 or fewer qualified employees during the taxable year.

(2) CREDIT ALLOWED FOR ONLY 2 TAXABLE YEARS.—No credit shall be determined under subsection (a) during any taxable year beginning after December 31, 2012.

(d) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking "plus" at the end of paragraph (34), by inserting at the end of paragraph (35) and inserting "the" and by adding at the end the following new paragraph:

"(36) in the case of a qualified small employer (as defined in section 55R(e)), the small business employee health coverage credit determined under section 43R(a)."

(e) AMENDMENTS APPLICABLE TO TITLES.—The amendment made by this section shall apply to taxable years beginning after December 31, 2012.

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYER HEALTH COVERAGE EXPENSES

SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

"SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

"(1) QUALIFIED EMPLOYER.—For purposes of this section—

(A) the term 'qualified employer' means any employer for any taxable year if—

(i) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

(ii) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

(2) QUALIFIED EMPLOYER.—The term 'qualified employer' means any employer for any taxable year if—

(i) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

(ii) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

(3) LIMITATIONS.—

(a) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—For purposes of section 38, in the case of an employer who employs more than 10 qualified employees during the taxable year, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(B) APPLICABLE PERCENTAGE.—

(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under this section for such taxable year is an amount equal to the product of—

(A) the average annual employee compensation of such employer for such taxable year

and

(B) the applicable percentage.

(3) LIMITATIONS.—

(a) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—For purposes of section 38, in the case of an employer who employs more than 10 qualified employees during the taxable year, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(b) APPLICABLE PERCENTAGE.—

(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under this section for such taxable year is an amount equal to the product of—

(A) the average annual employee compensation of such employer for such taxable year

and

(B) the applicable percentage.

(3) LIMITATIONS.—

(a) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—For purposes of section 38, in the case of an employer who employs more than 10 qualified employees during the taxable year, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(b) APPLICABLE PERCENTAGE.—

(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under this section for such taxable year is an amount equal to the product of—

(A) the average annual employee compensation of such employer for such taxable year

and

(B) the applicable percentage.
If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 533. INCREASE IN PENALTY FOR NON-QUALIFIED PARTNERSHIP DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNTS.

(a) In General.—Subparagraph (A) of section 223(f)(4) of the Internal Revenue Code of 1986 is amended—

(1) by inserting ‘‘or any entity described in subsection (l)(21),’’ after ‘‘or (20)’’ in the matter preceding subparagraph (A),

(2) by inserting ‘‘or any entity described in subsection (l)(21), or (o)(3)(A),’’ in subparagraph (F)(ii), and

(3) by inserting ‘‘or any entity described in subsection (l)(21), after ‘‘or (20),’’ both places it appears in the matter after subparagraph (F).

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

SEC. 534. DENIAL OF DEDUCTION FOR FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS WHICH HAVE BEEN EXCLUDED FROM GROSS INCOME.

(a) In General.—Section 139A of the Internal Revenue Code of 1986 is amended by striking ‘‘10 percent’’ and inserting ‘‘20 percent’’.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2019.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

SEC. 541. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

(a) In General.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

‘‘(21) Disclosure of Return Information to Carry Out Health Insurance Exchange Subsidies.—

‘‘(A) In General.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 308 of the Affordable Health Care for America Act, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act. Such return information shall be limited to—

‘‘(i) taxpayer identity information with respect to such taxpayer,

‘‘(ii) the filing status of such taxpayer,

‘‘(iii) the adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

‘‘(iv) the number of dependents of the taxpayer,

‘‘(v) other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

‘‘(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

‘‘(B) Restriction on Use of Disclosed Information.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act, and providing for the repayment of any such credit which was in excess of such appropriate amount.’’.

(b) Procedures and Recordkeeping Related to Disclosures.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting ‘‘, or any entity described in subsection (1)(21),’’ after ‘‘or (20)’’ in the matter preceding subparagraph (A),

(2) by inserting ‘‘or any entity described in subsection (1)(21), or (o)(3)(A),’’ in subparagraph (F)(ii), and

(3) by inserting ‘‘or any entity described in subsection (1)(21), after ‘‘or (20),’’ both places it appears in the matter after subparagraph (F).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 542. OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS THROUGH CAFETERIA PLANS.

(a) In General.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

‘‘(8) Certain Exchange-Participating Health Benefits Plans Not Qualified.—

‘‘(A) In General.—The term ‘qualified benefit’ shall not include any exchange-participating health benefits plan (as defined in subsection (c) of the Affordable Health Care for America Act).’’.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking ‘‘For purposes of this section, the term ‘qualified benefit’ shall not include any exchange-participating health benefits plan (as defined in subsection (c) of the Affordable Health Care for America Act).’’,

(2) by inserting ‘‘for part III of subchapter B of chapter 1 of such Code) is amended by inserting ‘‘, or any entity described in paragraph (2) of section 7702B(B) of such Code, as redesignated by subsection (a), is amended by striking ‘‘or (A)’’ and inserting ‘‘or (B)’’,

(b) Conforming Amendments.—Subsection (f) of section 7702B of such Code is amended by striking ‘‘PART-MAIN-TAINED’’ in the heading thereof and inserting ‘‘GOVERNMENT’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2010.

SEC. 543. EXCLUSION FROM GROSS INCOME FOR MEDICAL CARE PROVIDED FOR INDIANS.

(a) In General.—Part III of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

‘‘SEC. 139D. MEDICAL CARE PROVIDED FOR INDIANS.

‘‘(a) In General.—Gross income does not include—

‘‘(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the Indian Health Service,

‘‘(2) medical care provided by an Indian tribe or tribal organization to a member of an Indian tribe (including for that purpose, coverage that extends to such member’s spouse or dependents) under an agreement having the effect of accident or health insurance; or

‘‘(3) the value of accident or health plan coverage provided by an Indian tribe to an Indian tribe or tribal organization for medical care to a member of an Indian tribe (including for that purpose, coverage that extends to such member’s spouse or dependents) under an accident or health plan or through an arrangement having the effect of accident or health insurance; and

‘‘(4) any other medical care provided by an Indian tribe that supplements, replaces, or otherwise facilitates the programs and services provided by the Federal Government to Indian tribes or Indians.

‘‘(b) Definitions.—For purposes of this section—

‘‘(1) In General.—The terms ‘accident or health insurance’ and ‘accident or health plan’ have the same meaning as when used in section 101B and 106.

‘‘(2) MEDICAL CARE.—The term ‘medical care’ has the meaning given such term in section 213.

‘‘(3) DEPENDENT.—The term ‘dependent’ has the meaning given such term in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B).

‘‘(4) INDIAN TRIBE.—The term ‘Indian tribe’ means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or recognized village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the purpose of the programs and services provided by the United States to Indians because of their status as Indians.

‘‘(B) any State long-term care plan.,’’.

‘‘(C) Any Entity.—The term ‘any entity’ includes—

‘‘(i) any entity described in section 139A(B) of such Code,

‘‘(ii) the term ‘qualified benefit’ shall not include any exchange-participating health benefits plan (as defined in subsection (c) of the Affordable Health Care for America Act).’’.

(b) Conforming Amendments.—Subsection (f) of section 7702B of such Code is amended by inserting ‘‘20 percent’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2010.
"(5) THIRAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term in section 410 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 3361).

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 139C the following item:

"Sec. 139D. Medical care provided for Indians."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales and leases treated as sales for purposes of section 55 of the Internal Revenue Code of 1986.

SEC. 55C. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) In General.—Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter D—Medical Devices

"Sec. 4061. Medical devices.

"Sec. 4061. MEDICAL DEVICES.

"(a) In General.—There is hereby imposed a surcharge on the first taxable sale of any medical device (as defined in section 163(d)) of a type (and in the ordinary course of trade) intended for human use and sold for use for the purpose of manufactuer, or importer referred to in subparagraph (B)(i) the amount of the tax paid by such seller under this section with respect to such sale.

"(B) SPECIFIED CONTRACT SALE.—For purposes of this section the term 'specified contract sale' means, with respect to any medical device, the first taxable sale of such device if—

(i) the seller is the producer, manufacturer, or importer of such device, and

(ii) the price at which such device is so sold is determined in accordance with a contract between the producer, manufacturer, or importer of such device and the person to whom such device is so sold.

"(C) SPECIAL RULES RELATED TO CREDITS AND REFUNDS.—In the case of any credit or refund under section 6416 of the tax imposed under this section on a specified contract sale of a medical device, notwithstanding any provision of this Act, any credit or refund shall be allowed or made only if the seller has filed with the Secretary the written consent of the producer, manufacturer, or importer referred to in subparagraph (B)(i) to the allowance of such credit or the making of such refund, and

(i) the amount of tax taken into account under subparagraph (A) shall be reduced by the amount of such credit or refund.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6416(b) of such Code is amended by inserting "or 4061" after "under section 4061.

(2) By adding at the end the following: "In the case of the tax imposed by section 4061, subparagraphs (B), (C), (D), and (E) shall not apply.

(3) The table of subchapters for chapter 31 of such Code is amended by adding at the end the following new item:

"Subchapter D. Medical devices.

"(a) In General.—Rules similar to the rules of section 4217 shall apply to taxable sales of such devices, for purposes of the provisions of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

(1) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section..."
6041 of the Internal Revenue Code of 1986 is amended—
(1) by inserting “amounts in consideration for property,” after “wages,”
(2) by inserting “related-party payments,” after “emoluments, or other,” and
(3) by inserting “gross proceeds,” after “settling forth the amount of such”.

(c) The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 534. REPEAL OF WORLDWIDE ALLOCATION OF INTEREST.

(a) In General.—Section 864 of the Internal Revenue Code of 1986 is amended by striking subsection (f) and by redesignating subsection (g) as subsection (f).

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 555. EXCLUSION OF UNPROCESSED FUELS FROM THE CELLOSUCIC BIOFUEL PRODUCER CREDIT.

(a) In General.—Subparagraph (E) of section 48(b)(6) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

”(III) the term ‘transitional biofuel’ shall not include any fuel if—
(I) more than 4 percent of such fuel (determined by weight) is a combination of water and sediment, or
(II) the ash content of such fuel is more than 1 percent (determined by weight).”.

(b) Effective Date.—The amendment made by this section shall apply to fuels sold or used after the date of the enactment of this Act.

PART 2—PREVENTION OF TAX AVOIDANCE

SEC. 561. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) In General.—Section 894 of the Internal Revenue Code of 1986 relating to income affected by the ‘deductible related-party payment’ shall be amended by adding at the end the following new subsection:

”(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—
(1) In General.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term ‘deductible related-party payment’ means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are members of the same foreign controlled group of entities.

(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—
(A) In General.—The term ‘foreign controlled group of entities’ means a controlled group of entities the common parent of which is a foreign corporation.

(B) CONTROLLED GROUP OF ENTITIES.—
The term ‘controlled group of entities’ means a controlled group of corporations as defined in section 595(a)(1), except that—
(1) ‘more than 50 percent’ shall be substituted for ‘at least 80 percent’ each place it appears therein, and
(2) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 593.

A partnership or any other entity (other than certain foreign corporations, as defined in section 593(b)(1)) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 594(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this section).

FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term ‘foreign parent corporation’ means, with respect to any deductible related-party payment, the common parent of any controlled group of entities referred to in paragraph (3A).

(5) REGULATIONS.—The Secretary may prescribe such regulations as are necessary or appropriate to carry out the purposes of this section, including regulations or other guidance which provide for—
(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and
(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.”.

(b) Effective Date.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 562. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) In General.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

”(q) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—
(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—
(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer’s economic position, and
(B) the taxpayer has a substantial purpose for entering into such transaction.

(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT SHARING.—
(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraph (A) and paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

(B) TREATMENT OF PERS AND FOREIGN TAXES.—The expenses and other related-party payments and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

(3) STATES APPLICABLE AS TAX BENEFITS.—
For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

(4) FINANCIAL ACCOUNTING BENEFITS.—
For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

(C) COMMON DOCTRINE NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.”.

(b) Penalty for Underpayments Attributable to Transactions Lacking Economic Substance.

(a) In General.—Subsection (b) of section 6664 of such Code is amended by inserting after paragraph (5) the following new paragraph:

”(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o) or failing to meet the requirements of any similar rule of law).”.

(2) Increased Penalty for Nondisclosed Transactions.—Section 6662 of such Code is amended by adding at the end the following new subsection:

”(i) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed economic substance transactions, subsection (a) shall be applied with respect to such portion by substituting ‘40 percent’ for ‘20 percent’. “

(2) Nondisclosed economic substance transactions.—For purposes of this subsection, the term ‘nondisclosed economic substance transaction’ means any portion of a transaction described in subsection (b)(6) with respect to which the Secretary does not have adequate information to determine the tax treatment are not adequately disclosed in the return or in a statement attached to the return.

(c) Special Rule for amended returns.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.”.

(3) Conforming Amendment.—Subparagraph (B) of section 6662(a)(2) of such Code is amended—

(A) by striking “section 6662(b)” and inserting “subsections (h) or (i) of section 6662, as applicable”;

(B) by striking “gross valuation misstatement penalty” in the heading and inserting “certain increased underpayment penalties”.

(c) Reasonable Cause Exception Not Applicable to Noneconomic Substance Transactions and Tax Shelters.—The reasonable cause exception as provided in section 6664 for underpayments shall not apply to section 6664 of such Code is amended—
(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,
(B) by striking paragraph (2)” in paragraph (4)(A), as so redesignated, and inserting “paragraph (3),” and
(C) by inserting after paragraph (1) the following new paragraph:

“(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6622(d)(2)(C) or transactions described in section 6622(b)(6).”

(2) REASONABLE CAUSE EXCUSE FOR REPORTABLE TRANSACTION UNDERSTATEMENTS.—

Subsection (d) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,
(B) by striking “paragraph (2)(C)” in paragraph (4), as so redesignated, and inserting “paragraph (3)(C),” and
(C) by inserting after paragraph (1) the following new paragraph:

“(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of a reportable transaction underpayment which is attributable to one or more tax shelters (as defined in section 6622(d)(2)(C)) or transactions described in section 6622(b)(6).”

(3) PENALTY FOR ERROR NO CLAIM FOR REFUND OR CREDIT TO NON-ECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (a) as subsection (b), inserting after such subsection the following new subsection:

“(c) TREATMENT AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6622(d)(2)(C) or transactions described in section 6622(b)(6) shall not be treated as having a reasonable basis.”.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

(2) UNDERPAYMENTS.—The amendments made by subsections (b) and (c) shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(3) UNDERSTATEMENTS.—The amendments made by subsection (a) shall apply to understatements attributable to transactions entered into after the date of the enactment of this Act.

(4) TAX BURDENS AND CREDITS.—The amendments made by subsection (d) shall apply to refunds and credits attributable to transactions entered into after the date of the enactment of this Act.

SEC. 563. CERTAIN LARGE OR PUBLICLY TRADED PERSONS MADE SUBJECT TO A MORE LIKELY THAN NOT STANDARD FOR AVOIDING PENALTIES ON UNDERPAYMENTS.

(a) IN GENERAL.—Section (c) of section 6664 of the Internal Revenue Code of 1986, as amended by section 562, is amended—

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively,

(2) by striking “paragraph (3)” in paragraph (4)(A), as so redesignated, and inserting “paragraph (4),” and

(3) by inserting after paragraph (2) the following new paragraph:

“(3) SPECIAL RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—In the case of any specified person, paragraph (1) shall apply to the portion of an underpayment which is attributable to any item only if such person has a reasonable basis for the tax treatment of such item by such person is more likely than not the proper tax treatment of such item.

“(B) SPECIFIED PERSON.—For purposes of this paragraph, the term ‘specified person’ means—

(i) any person required to file periodic or other returns under section 152 of the Securities Exchange Act of 1934, and

(ii) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of clause (i).”.

(b) NONAPPLICATION OF SUBSTANTIAL AUTHORITY AND REASONABLE BASIS STANDARDS FOR REDUCING UNDERSTATEMENTS.—Paragraph (2) of section 6662(d) of such Code is amended by adding at the end the following new subparagraph:

“(D) REDUCTION NOT TO APPLY TO CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subparagraph (B) shall not apply to any specified person (as defined in section 6664(c)(3)(B)).”

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(2) NONAPPLICATION OF UNDERSTATEMENT REDUCTION.—The amendment made by subsection (a) shall not apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

PART 3.—PARITY IN HEALTH BENEFITS

SEC. 571. CERTAIN INTEGRATED BENEFITS APPLICABLE TO SPOUSES AND DEPENDENTS EXTENDED TO ELIGIBLE BENEFICIARIES OF EMPLOYEES.

(a) APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.—

(1) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans), as added by section 531, is amended by adding at the end the following new subparagraph:

“(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term ‘eligible beneficiary’ means any individual who is eligible to receive benefits or coverage under an accident or health plan.

(3) REDUCTION NOT TO APPLY TO CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subparagraph (B) of section 106(d) of such Code is amended by redesignating paragraphs (23) and inserting ‘,’ and by inserting after paragraph (23) the following new paragraph:

“(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 106(b) to section 106(g).”.

(b) EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Paragraph (1) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

(A) the taxpayer,

(B) the taxpayer’s spouse,

(C) the taxpayer’s dependents,

(D) any individual who—

(i) satisfies the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

(iii) meets the requirements of section 152(d)(1)(C), and

(E) one individual who—

(i) does not satisfy the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

(iii) meets the requirements of section 152(d)(1)(C), and

(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).

(2) CONFORMING AMENDMENTS.—Subparagraph (B) of section 162(b)(2) of such Code is amended by inserting ‘, any dependent, or any eligible beneficiary (within the meaning of section 106(g))’ after ‘spouse’.

(c) EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO
HEALTH REIMBURSEMENT ARRANGEMENTS.—
SEC. 1001. TABLE OF CONTENTS OF DIVISION.
(a) TABLE OF CONTENTS.—The Amendments to title I of the Employee Retirement Income Security Act of 1974 (relating to tax-exempt employee plans) and title V of the Internal Revenue Code of 1986 (relating to certain flexible spending arrangements) made by this section shall apply to taxable years beginning after December 31, 2009.

DIVISION B—MEDIARE AND MEDICAID IMPROVEMENTS
SEC. 1001. TABLE OF CONTENTS OF DIVISION.
The table of contents of this division is as follows:
Sec. 1101. Title of contents of division.
SUBTITLE A—IMPROVING HEALTH CARE VALUE
Sec. 1102. Provisions Related to Medicare

PART A—MARKET BASKET UPDATES
Sec. 1103. Skilled nursing facility payment update.
Sec. 1104. Inpatient rehabilitation facility payment update.
Sec. 1105. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART B—OTHER MEDICARE
Sec. 1106. Payments to skilled nursing facilities.
Sec. 1107. Medicare DSH report and payment adjustments in response to coverage expansion.
Sec. 1108. Extension of hospice regulation moratorium.
Sec. 1109. Permitting physician assistants to order post-hospital extended care services and to provide for recognition of attending physicians as attending physicians to serve hospice patients.

SUBTITLE B—PROVISIONS RELATED TO PART B
PART 1—PHYSICIANS’ SERVICES
Sec. 1121. Resource-based feedback program for physicians in Medicare.
Sec. 1122. Misvalued codes under the physician fee schedule.
Sec. 1123. Payments for efficient areas.
Sec. 1124. Modifications to the Physician Quality Reporting Initiative.
Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES
Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 3—OTHER PROVISIONS
Sec. 1141. Rental and purchase of power to improve Medicare.
Sec. 1141A. Election to take ownership, or to lease, of certain equipment.

SUBTITLE C—PROVISIONS RELATED TO MEDICARE PART A AND B
Sec. 1151. Reducing potentially preventable hospital readmissions.
Sec. 1152. Post acute care services payment reform plan and bundling pilot program.
Sec. 1153. Home health payment update for 2010.
Sec. 1154. Payment adjustments for home health care.
Sec. 1155. Incorporating productivity improvements into market basket update for home health services.
Sec. 1155A. MedPAC study on variation in home health margins.
Sec. 1156. MedPAC study on variation in home health margins.
Sec. 1158. Revision of Medicare payment systems to address geographic inequities.
Sec. 1159. Institute of Medicine study of geographic adjustment factors under Medicare.

SUBTITLE D—MEDICARE ADVANTAGE REFORMS
PART 1—PAYMENT AND ADMINISTRATION
Sec. 1161. Phase-in of payment based on fee for service costs; quality bonus payments.
Sec. 1162. Authority for Secretarial coding intensity adjustment authority.
Sec. 1163. Simplification of annual beneficiary eligibility.
Sec. 1164. Extension of reasonable cost contracts.
Sec. 1165. Limitation of waiver authority for employer group plans.
Sec. 1166. Improving risk adjustment for payments.
Sec. 1167. Elimination of MA Regional Plan Stabilization Fund.
Sec. 1168. Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD
Sec. 1171. Limitation on cost-sharing for individual health services.
Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension.
Sec. 1173. Information for beneficiaries on MA plan administrative costs.
Sec. 1174. Strengthening audit authority.
Sec. 1175. Authority to deny plan bids.
Sec. 1175A. State authority to enforce standardized marketing requirements.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS
Sec. 1176. Limitation on enrollment outside open enrollment period of individual into chronic care specialized MA plans for special needs individuals.
Sec. 1177. Extension of authority of special needs plans to restrict enrollment; service area moratorium for certain SNPs.
Sec. 1178. Extension of Medicare senior housing plans.
Sec. 1179. Improvements to Medicare Part D.
Sec. 1181. Elimination of coverage gap.
Sec. 1182. Discounts for certain part D drugs in original coverage gap.
Sec. 1183. Repeal of provision prohibiting submission of claims by pharmacies located in or contracting with long-term care facilities.
Sec. 1184. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
Sec. 1185. No mid-year formulary changes permitted.
Sec. 1186. Negotiation of lower covered part D drug prices on behalf of Medicare beneficiaries.
Sec. 1187. Accurate dispensing in long-term care facilities.
Sec. 1188. Free generic fill.
Sec. 1189. State certification prior to waiver of licensure requirements under Medicare prescription drug program.

SUBTITLE E—IMPROVEMENTS TO MEDICAID
Sec. 1191. Telehealth expansion and enhancements.
Sec. 1192. Extension of outpatient hold harmless.
Sec. 1193. Extension of section 508 hospital reclassifications.
Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations.
Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program.
Sec. 1643. Access to certain information on renal dialysis facilities.
Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.
Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.
Sec. 1646. Requiring provider and supplier payments under Medicare to be made through direct deposit or electronic funds transfer (EFT) as insured depository institutions.
Sec. 1647. Inspector General for the Health Choices Administration.

Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse
Sec. 1651. Access to Information Necessary to Identify Fraud, Waste, and Abuse.
Sec. 1652. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.
Sec. 1653. Compliance with HIPAA privacy and security standards.
Sec. 1654. Disclosure of Medicare Fraud and Abuse Hotline Number on Explanation of Benefits.

TITLE VII—MEDICAID AND CHIP
Subtitle A—Medicaid and Health Reform
Sec. 1701. Eligibility for individuals with income below 150 percent of the Federal poverty level.
Sec. 1702. Requirements and special rules for certain Medicaid eligible individuals.
Sec. 1703. CHPP and Medicaid maintenance of eligibility.
Sec. 1704. Reduction in Medicaid DSH.
Sec. 1705. Expanded outstationing.
Subtitle B—Prevention
Sec. 1714. State eligibility option for family planning services.
Subtitle C—Access
Sec. 1721. Payments to primary care practitioners.
Sec. 1722. Medical home pilot program.
Sec. 1723. Translation or interpretation services.
Sec. 1724. Optional coverage for freestanding birth center services.
Sec. 1725. Inclusion of public health clinics under the vaccines for children program.
Sec. 1726. Requiring coverage of services of podiatrists.
Sec. 1728A. Requiring coverage of services of optometrists.
Sec. 1729. Therapeutic foster care.
Sec. 1729. Assuring adequate payment levels for services.
Sec. 1729. Preserving Medicaid coverage for youths upon release from public institutions.
Sec. 1730. Quality measures for maternity and adult health services under Medicaid and CHIP.
Sec. 1730A. Accompanying care organization pilot program.
Sec. 1730B. FQHC coverage.

Subtitle D—Coverage
Sec. 1731. Optional Medicaid coverage of low-income HIV-infected individuals.
Sec. 1732. Extending transitional Medicaid Assistance (TMA).
Sec. 1733. Requirement of 12-month continuous coverage under certain CHIP programs.
Sec. 1734. Preventing the application under CHIP of coverage waiting periods for certain children.
Sec. 1735. Adult day health care services.
Sec. 1736. Medicaid coverage for citizens of Freely Associated States.
Sec. 1737. Continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services.
Sec. 1738. State option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high prescription costs.
Sec. 1739. Provisions relating to community living assistance services and supports (CLASS).
Sec. 1739A. Sense of Congress regarding Community First Choice Option to provide Medicaid Coverage of Community-Based Attendant Services and Supports.
Sec. 1741. Payments to pharmacists.
Sec. 1742. Prescription drug rebates.
Sec. 1743. Extension of prescription drug discounts to enrollees of Medicaid managed care organizations.
Sec. 1744. Payments for graduate medical education.
Sec. 1745. Nursing facility Supplemental Payment Program.
Sec. 1746. Report on Medicaid payments.
Sec. 1747. Reviews of Medicaid.
Sec. 1748. Extension of delay in managed care organization provider tax elimination.
Sec. 1749. Extension of ARRA increase in FMAP.
Subtitle E—Waste, Fraud, and Abuse
Sec. 1751. Health care acquired conditions.
Sec. 1752. Evaluations and reports required under Medicaid Integrity Program.
Sec. 1753. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.
Sec. 1754. Overpayments.
Sec. 1755. Managed care organizations.
Sec. 1756. Termination of provider participation under Medicaid and CHIP if terminated under Medicare or other State plan or child health plan.
Sec. 1757. Medicaid and CHIP exclusion from participation required to certain ownership, control, and management affiliations.
Sec. 1758. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.
Sec. 1759. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.
Sec. 1760. Denial of payments for litigation-related misconduct.
Sec. 1761. Mandatory State use of national correct coding initiative.
Subtitle F—Payments to the Territories
Sec. 1771. Payment to territories.
Subtitle G—Payments to the Territories
Sec. 1771A. Payments to the Territories.

TITLE VIII—REVENUE-RELATED PROVISIONS
Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration’s outreach to eligible individuals.
Sec. 1802. Comparative Effectiveness Research Trust Fund; financing for Trust Fund.

TITLE IX—MISCELLANEOUS PROVISIONS
Sec. 1901. Repeal of trailer provision.
Sec. 1902. Repeal of comparative cost adjustment (CCA) program.
Sec. 1903. Extension of gainsharing demonstration.
Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.
Sec. 1905. Improved coordination and protection for dual eligibles.
Sec. 1906. Assessment of Medicare cost-intensive diseases and conditions.
Sec. 1907. Establishment of Center for Medicare and Medicaid Innovation within CMS.
Sec. 1908. Application of emergency services laws.
Sec. 1909. Disregard under the Supplemental Security Income program of compensation for participation in clinical trials for rare diseases.

TITLE I—IMPROVING HEALTH CARE VALUE
Subtitle A—Provisions Related to Medicare Part A

PART I—MARKET BASKET UPDATES
SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.
(a) IN GENERAL.—Section 1886(e)(4)(B)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(B)(ii)) is amended—
(1) in subclause (I), by striking “and” at the end;
(2) by redesignating subclause (IV) as subclause (V); and
(3) by inserting after subclause (III) the following new subclauses:
“(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;”
“(V) for fiscal year 2010, the rate computed for the previous fiscal year; and”,
(b) DELAYED EFFECTIVE DATE.—Section 1886(e)(4)(B)(ii)(V) of the Social Security Act, as inserted by subsection (a), shall not apply to payment for days before January 1, 2010.

SEC. 1102. INPATIENT REHABILITATION FACILITY PAYMENT UPDATE.
(a) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C.
1395w(j)(3)(C)) is amended by striking “and 2009” and inserting “through 2010.”

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET INDEXES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1395w(b)(3)(B) of the Social Security Act (42 U.S.C. 1395w(b)(3)(B)) is amended—

(1) in clause (ii), by inserting “(ii) For purposes of this subparagraph,” and inserting “(ii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (I),”;

(2) in the first sentence of clause (i)(I), by inserting “(but not below zero)” after “shall be reduced;”;

(3) in the first sentence of clause (ix)(I), by inserting “(determined without regard to clause (iii)(II))” after “clause (i)” the second time it appears; and

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

“(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset in the form of a reduction in such increase or change equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm productivity (as recently published in final form before the promulgation or publication of such increase for the year or period involved). Except as otherwise provided, any reference to the percentage increase described in this clause shall be a reference to the percentage described in subclause (I) minus the percentage change under this subclause.”;

(2) in the first sentence of clause (viii)(I), by inserting “(but not below zero)” after “shall be reduced;”;

3. The amendments made by subsection (a) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to discharges occurring on or after January 1, 2010.

(B) SNF AND IRF.—The amendments made by subsections (b) and (d) shall apply to annual increases effected for fiscal years beginning with fiscal year 2011.

(3) Hospice Care.—Subclause (VII) of section 1841(i)(11)(C) of the Social Security Act (42 U.S.C. 1395yy(j)(3)(C)) is amended by inserting after “the market basket percentage increase” the following “(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(ii)(II)).”;

(e) EFFECTIVE DATES.—

(1) IPPS.—The amendments made by subsection (a) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to days of care occurring on or after January 1, 2010.

(2) SNF AND IRF.—The amendments made by subsection (f) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to days of care occurring on or after January 1, 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG–IV and under the RUG–IV classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1888(e)(4)(G)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(ii)) for fiscal year 2010 by making such adjustment to the factor described in paragraph (E) and consistent with subparagraph (i) of section 1888(e)(4)(G)(ii) of such Act (42 U.S.C. 1395yy(e)(4)(G)(ii)) for fiscal year 2010 in a manner such that the estimated expenditures under such future skilled nursing facility services classification system for a fiscal year beginning with fiscal year 2011 with such case mix indexes would be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under such future skilled nursing facility services classification system for such year without such changes.

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall add a separate payment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010.

(b) OUTLIER POLICY FOR NTA AND THERAPY SERVICES.—Section 1886(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following new paragraph:

“(3) OUTLIER POLICY FOR NTA AND THERAPY SERVICES.—For non-therapy ancillary services under this section with respect to non-therapy ancillary services in the case of such outliers and the number of days in such stay.

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.
"(C) BUDGET NEUTRALITY.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year shall not exceed 1 percent of the total payments projected or estimated to be based on the prospective payment system under this subsection for the fiscal year.

(2) COORDINATION WITH MEDICAID DSH.—(A) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals, including bed size, consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs and the extent such costs remain.

(3) CONSTRUCTION.—Nothing in the amendment to paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, the Secretary shall estimate the aggregate reduction in the amount of Medicare DSH payment that would be expected to result from the adjustment under paragraph (1)(A).

(4) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall make the additional payment to a hospital as described in paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the estimated aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH payment made by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care costs shall receive a greater increase.

(c) MEDIICARE DSH.—(A) In this section, the term “Medicare DSH” means adjustments in payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

(B) The increase in the national rate of uninsurance as a result of this Act as determined under part B of title XVIII of such Act.

III. EXTENSION OF HOSPICE REGULATION MORTARIUM.

Section 4301(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) amended—

(1) by striking “October 1, 2009” and inserting “October 1, 2010”; and

(2) by striking “October 1, 2009” and inserting “for fiscal years 2009 and 2010”.

IV. PERMITTING PHYSICIANS ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES AND TO PROVIDE FOR RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w(d)(5)(F)) with respect to payments made by such equivalent tool as specified by the Secretary, to:—

(i) attribute items and services, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B)(3); and

(iii) aggregate items and services attributed to a physician under clause (i) into a composite measure per individual.

(d) FEEDBACK PROGRAM.—The Secretary shall engage in efforts to disseminate reports under this subsection. In disseminating such reports, the Secretary shall consider the following:

(i) Direct meetings between contracted physicians, facilitated by the Secretary, to discuss the contents of reports under this subsection, including any reasons for divergence from local or national averages.

(ii) Mailings or other methods of communication that facilitate large-scale dissemination of the reports, the Secretary shall consider the following:

(i) attribute items and services, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B)(3); and

(iii) aggregate items and services attributed to a physician under clause (i) into a composite measure per individual.

(E) EVALUATION AND EXPANSION.—

(i) EVALUATION.—The Secretary shall evaluate the methods specified in subparagraph (d) with respect to their efficacy in changing practice patterns to improve quality and decrease costs.
(i) EXPANSION.—Taking into account the cost of each method specified in subparagraph (D), the Secretary shall develop a plan to disseminate reports under this subsection in a manner that prioritizes the dissemination in the regions and cities of the country with the highest utilization of services under this title. To the extent practicable, reports under this subsection shall be disseminated to increasing numbers of physicians each year, such that during 2014 and subsequent years, reports are disseminated at least to physicians with utilization rates among the highest 5 percent of the nation, subject the authority to focus under subsection (4).

(F) ADMINISTRATION.—

(i) Chapter 35 of title 44, United States Code shall not apply to this paragraph.

(ii) Notwithstanding any other provision of law, the Secretary may implement the provisions of this paragraph by program instruction or otherwise.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

"(K) POTENTIALLY MISVALUED CODES.—

(i) IN GENERAL.—The Secretary shall—

(1) TRANSLATE PETITIONS.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(2) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i), the Secretary shall examine (a) methodology for development of the RVRV (the so-called ‘Harvard-valued codes’); and such other codes determined to be appropriate by the Secretary.

(3) REVIEW AND ADJUSTMENTS.—

(I) The Secretary may use existing processes to review recommendations on the relative values identified for services described clause (1)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other research and determine that an appropriate adjustment shall be made to the relative values identified for services described clause (1)(II).

(III) The Secretary may use analytic contracts to identify and analyze services described as being potentially misvalued under clause (1)(II).

(IV) The Secretary may coordinate the validation under this paragraph, using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(V) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the relative value units described under subsection (1)(II).

(b) IMPLEMENTATION.—

(i) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Office, 3000 William Jefferson Clinton Federal Building, Washington, D.C. 20501, not otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Office, 3000 William Jefferson Clinton Federal Building, Washington, D.C. 20501, as and each subsequent fiscal year. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(ii) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraph (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 1505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(E) FOCUSING CMS RESOURCES ON POTENTIALLY MISVALUED CODES.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w(a)) is amended by adding at the end the following new subsection:

"(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount that would otherwise be made for such services under this part, there shall also be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

(2) IDENTIFICATION OF EFFICIENT AREAS.—

(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization for such services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to eliminate the effect of geographic adjustments in payment rates.

(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is equivalent to a county described in subparagraph (A).

"(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) VALIDATING RELATIVE VALUE UNITS.—

(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, technical skill, physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(i)

(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

POSTING ON WEBSITE.—With respect to a year for which a county or other area under subparagraph (A) or (B) is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.

SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY REPORTING INITIATIVE.

(a) MODIFICATIONS.—Section 1833(m)(5) of the Social Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by adding at the end the following new subparagraph:

"(PQRI).

QUALITY REPORTING INITIATIVE
null
month during which payment is made for the rental of the Group 3 Support Surface under clause (i). Such title shall be transferred to the individual only if the individual notifies the supplier not later than 1 month after the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to a durable medical equipment not later than January 1, 2011.

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHIOCEPHALIC CATHETERS.

Section 1833(h)(16)(C) of the Social Security Act (42 U.S.C. 1395t(h)(16)(C)), as amended by section 172 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking, the first place it appears, “January 1, 2010” and inserting “January 1, 2012.”

SEC. 1143. HOSPITALIZATION THERAPY REPORT TO CONGRESS.

Not later than July 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran’s health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of the services provided by home infusion therapy providers to their patients in such programs.

(b) Authorization of Adjustment for Certain Hospitals.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395t(i)) is amended by adding at the end the following new paragraphs:

“(8) The Secretary shall require, as a condition of the agreement described in section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395t(i)(7)) is amended—

(1) in subparagraph (B), by inserting ‘‘(3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. (3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program. (4) Recommendations, if any, on the structure of a payment system under the Medicare Advantage program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy. The Medicare program.”

Sec. 1146. PAYMENT FOR IMAGING SERVICES.

(a) Adjustment in Practice Expense to Reflect a Presumed Level of Utilization.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) by striking “(5)” and inserting “(4)”;

and

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

“(C) Adjustment in Technical Component Discount on Single-Session Imaging Services.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the presumed utilization of imaging equipment of 75 percent.”;

and

(C) Adjustment in Technical Component Discount on Single-Session Imaging Services.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the presumed utilization of imaging equipment of 75 percent.”; and

(4) in subsection (c)(2)(B)(v), by adding at the end the following new paragraph:

“(D) Adjustment in Technical Component Discount on Single-Session Imaging Services.—For services furnished on or after January 1, 2012, the Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component of the final rule published by the Secretary in the Federal Register on November 21, 2005 (part
405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

“(IV) a supplier that has submitted an application for accreditation before August 1, 2009, shall retain the supplier’s provider or supplier number until an independent accreditation organization determines if such supplier complies with requirements under this paragraph.”;

and

SEC. 1147. DURABLE MEDICAL EQUIPMENT PRO-
STATEMENT—PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the implementation of procedure code 92936 as payment for one subsequent period of medical need for any subsequent period of medical need for such equipment as of such month shall continue to fur-

nish such equipment to such individual (except as of the 27th month of the 36 months described in subsection (b)(4)(D)).”;

SEC. 1149. TIMELY ACCESS TO POST-MAS-
TECTOMY EXTERNAL BREAST PROSTHESIS GAR-
MENTS.—Payment for post-mastectomy external breast prosthesis garments shall be pursued regardless of whether such items are supplied to the beneficiary prior to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary shall promulgate appropriate beneficiary access and utilization safeguards for such items supplied to a beneficiary prior to the mastectomy or other breast cancer surgical procedure.”

(b) EFFECTIVE DATE.—This amendment shall apply not later than January 1, 2011.

SEC. 1149A. PAYMENT FOR BIOSIMILAR BIO-
LOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the So-
cial Security Act (42 U.S.C. 1395w-3a) is amended—

(1) in subsection (b)(1)—

(A) in paragraph (A), by striking “or” at the end;

(B) in subparagraph (B), by striking the pe-

riod at the end and inserting “; or”; and

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

“(C) in the case of a biosimilar biological product (as defined in section 1847A(e)(6)), the sum of—

(1) the average sales price as determined using the methodology described in para-

graph (4) applied to such interchangeable and reference products for all National Drug Codes assigned to such products in the same manner as such paragraph (6) is applied to multiple source drugs; and

(2) 6 percent of the amount determined under subparagraph (C);”;

(2) in subsection (c)(6)—

(A) by amending subparagraph (D)(1) to read as follows:

“(A) a biological, including a reference bio-

logical product for a biosimilar product, but excluding—

(1) a biosimilar biological product;

(2) an interchangeable biological prod-

uct;

(3) a reference biological product for an interchangeable biological product; and

(4) a biological product for both an interchangeable biological product and a biosimilar product; or”;

and

(B) by adding at the end the following new subparagraphs:—

“(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biological product licensed as a biosimilar biological product under section 351(k) of the Public Health Service Act.

(I) INTERCHANGEABLE BIOLOGICAL PRO-
DUCT.—The term ‘interchangeable biological product’ means a biological product licensed as an interchangeable biological product under section 351(k) of the Public Health Service Act.

(J) REFERENCE BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means the biological product that is referred to in the application for a biosimilar or inter-

changeable biological product licensed under section 351(k) of the Public Health Service Act.

(k) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to pay-

ments for biosimilar biological products,
interchangeable biological products, and reference biological products beginning with the first day of the second calendar quarter after the date of the enactment of this Act.

SEC. 110B. ANNUAL REPORT ON DME COMPETITIVE BIDDING PROCESS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the methodology and procedures for establishing payment amounts under a program under title XVIII of the Social Security Act to acquire durable medical equipment and supplies through a competitive bidding process among manufacturers of such equipment and supplies. Such study shall address the following:

(1) Identification of types of durable medical equipment and supplies that would be appropriate for bidding under such a program.

(2) Recommendations on how to structure such an acquisition program in order to promote fiscal responsibility while also ensuring beneficiary access to high quality equipment and supplies.

(3) Recommendations on how such a program could be phased-in and on what geographic level would bidding be most appropriate.

(4) In addition to price, recommendations on criteria that could be factored into the bidding process.

(5) Recommendations on how suppliers could be qualified for participation in the bidding process.

(6) Comparison of such a program to the current competitive bidding program under Medicare for durable medical equipment, as well as any other similar Federal acquisition programs, such as the General Services Administration’s schedule purchase programs.

(7) Any other consideration relevant to the acquisition, supply, and service of durable medical equipment and supplies that is deemed appropriate by the Comptroller General.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the findings of the study under subsection (a).

Subtitle C—Provisions Related to Medicare Payment for Excess Readmissions

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS.

(a) HOSPITALS.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

"(pp) DURABLE MEDICAL PAYMENTS FOR EXCESS READMISSIONS.—

"(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under section (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

"(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating DRG payment amount’ means the payment amount under such section.

"(1) ADJUSTMENT FACTOR.—

"(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to—

(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(A)) for such fiscal year; or

(ii) the floor adjustment factor specified in subparagraph (C).

"(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to such applicable hospital for the applicable period; and

(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) FLOOR ADJUSTMENT FACTOR.—For purposes of paragraphs (B) and (F), the adjustment factor specified in this subparagraph for—

(1) fiscal year 2012 is 0.99;

(2) fiscal year 2013 is 0.98;

(3) fiscal year 2014 is 0.97; or

(4) a subsequent fiscal year is 0.95.

"(4) AVERAGE AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection—

"(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term ‘aggregate payments for excess readmissions’ means, for purposes of this subsection—

(1) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

(2) the number of admissions for such condition for such hospital for such fiscal year; and

(3) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for the applicable period for such fiscal year minus 1.

"(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term ‘aggregate payments for all discharges’ means, for a hospital for a fiscal year, the sum of the base operating DRG payment amount for all conditions for such hospital for such fiscal year.

"(C) EXCESS READMISSION RATIO.—

"(1) The term ‘excess readmission ratio’ means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

(i) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

(ii) the risk adjusted expected readmissions (as determined consistent with such methodology) for such hospital for such condition with respect to such applicable period.

"(ii) ADJUSTMENT.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

"(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under paragraph (1) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 90th percentile.

"(D) DEFINITIONS.—For purposes of this subsection—

"(A) APPLICABLE CONDITION.—The term ‘applicable condition’ means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

(ii) measures of such conditions—

(1) have been endorsed by the entity with a contract under section 1890(a); and

(2) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions to include the 3 conditions (for which measures have been endorsed as described in subparagraph (A)(1)(D) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(1)(D) but may apply such measures without such an endorsement.

"(C) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means—

(1) a hospital that is paid under section 1814(b)(3); and

(2) any other hospital that is paid under such section (B)(3).

"(D) APPLICABLE PERIOD.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

"(E) READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified for such measure. Inosef as the discharge relates to an applicable condition for which there is an endorsed measure in subparagraph (A)(1)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

"(F) DURABLE MEDICAL PAYMENTS.—There shall be no administrative or judicial review under section 1899, section 1878, or otherwise of—

(A) the determination of base operating DRG payment amounts;

(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(A), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges

H12673
under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (C); 

"(C) the measures of readmissions as described in subparagraph (A)(i) and (ii) and any or all of the other activities described in clause (iii); 

"(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in payment under paragraph (8)(B)(ii), the aggregate amount of the payment adjustment for a critical access hospital as described in subparagraph (E), and the form of payment made by the Secretary under paragraph (8)(D). 

"(7) IMPROVEMENTS IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine if such hospitals have taken steps to mitigate risk in order to reduce the likelihood of inpatient readmissions for applicable conditions or taken other inappropriate steps involving readmissions or transfers. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction. 

"(8) ASSISTANCE TO CERTAIN HOSPITALS.—

"(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps in paragraph (7) to address factors that may impact readmissions of individuals who are discharged from such a hospital with procedures beginning on or after October 1, 2011, the Secretary may make a payment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C). The Secretary shall provide priority to hospitals that serve Medicare beneficiaries at highest risk for readmission or for a poor transition from such a hospital to a post-hospital site of care. 

"(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

"(i) had (or, in the case of an 1814(b)(3) hospital, otherwise would have had) a disproportionate patient percentage (as defined in section 1886(k)(5)(F)) of at least 30 percent, using the latest available data as estimated by the Secretary; and 

"(ii) received the lowest assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E). 

"(C) CAPS.—

"(1) AGR Eg R A T E D C A P.—The aggregate amount of the payment adjustment under this paragraph for a fiscal year shall not exceed 6 percent estimated difference in spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1). 

"(2) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed a lower percent estimated difference in spending that would occur for such fiscal year for such hospital with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1). 

"(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise. 

"(E) USE OF ADDITIONAL PAYMENT.—

"(1) IN GENERAL.—Funding under this paragraph for targeted hospitals for activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, including transitional care services described in clause (ii) and any or all of the other activities described in clause (iii). 

"(2) TRANSITIONAL CARE SERVICES.—The transitional care services described in this clause are transitional care services furnished by a qualified transitional care provider under section 1861(s) of the Social Security Act for the individual who meets relevant experience and training requirements as specified by the Secretary that support a beneficiary under applicable periods, applicable conditions and measures of readmissions; " and 

"(D) by redesignating such paragraph as paragraph (6); and 

"(2) by inserting after paragraph (4) the following new paragraph: 

"(c) Adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in a fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection in a manner similar to the manner in which applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2)).". 

"(c) POST ACUTE CARE PROVIDERS.—

"(1) INTERIM POLICY.—

"(A) IN GENERAL.—With respect to a readmission to an applicable hospital or a critical access hospital under this section (1814(l) of the Social Security Act) from a post acute care provider (as defined in paragraph (3)) and such a readmission is not governed by section 421.531 of title 42, Code of Federal Regulations, if the claim submitted by such a post-acute care provider under title XVIII of the Social Security Act indicates that the individual was readmitted to a hospital from such a post-acute care provider or admitted from home and under the care of a home health agency within 30 days of discharge from an applicable hospital or critical access hospital, the payment under such title on such claim shall be the applicable percent specified in subparagraph (B), if otherwise made under the respective payment system under such title for such post-acute care provider if this subsection did not apply. In applying the previous sentence, the Secretary shall exclude a period of 1 day from the date the individual is first admitted to a hospital under the care of the post-acute care provider. 

"(B) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (A), the applicable percent is—

"(i) for fiscal or rate year 2012 is 0.996; 

"(ii) for fiscal or rate year 2013 is 0.993; and 

"(iii) for fiscal or rate year 2014 is 0.99. 

"(C) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished (as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal or rate year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

"(2) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—

"(A) IN GENERAL.—The Secretary of Health and Human Services shall develop and implement measures of readmissions for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act to adopt and apply such measures under this paragraph without such an endorsement. The Secretary shall expand such measures in a manner similar to the manner in which applicable conditions are expanded under paragraph (5)(B) of section 1886(p) of the Social Security Act, as added by subsection (a). 

"(B) APPLICABILITY OF NEW MEASURES.—The Secretary shall apply, on or after October 1, 2014, with respect to post acute care providers, policies similar to the policies applied with respect to acute care hospitals under the amendments made by subsection (a). The provisions of paragraph (1) shall apply with respect to any period on or after October 1, 2014, under such application date described in the previous sentence in the same manner as such provisions apply with respect to fiscal or rate year 2014.
in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term “post acute care provider” means—

(i) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (as defined in section 1886(h)(1)(A) of such Act);

(iii) a home health agency (as defined in section 1861(o) of such Act); and

(iv) a hospital (as defined in section 1861(cc) of such Act).

(B) OTHER TERMS.—The terms “applicable condition”, “applicable hospital”, and “readmission” have the meanings given such terms in section 1860(d)(5) of the Social Security Act, as added by subsection (a)(1).

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider appropriate approaches, including—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act (as in effect on August 28, 1988) for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or critical access hospital;

(B) developing measures of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physicians.

(e) REPORT.—The Secretary shall issue a public report on such study not later than one year after the date of the enactment of this Act.

(f) FUNDING.—For purposes of carrying out this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning after January 1, 2010. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM PLAN AND BUNDLING PILOT PROGRAM.

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a detailed plan to reform payment for post acute care services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the “Medicare program”). The goals of such payment reform plan shall be—

(A) improving the quality and efficiency of such services; and

(B) improving outcomes for individuals such as reducing readmission to hospitals from providers of such services.

(2) BUNDLING POST ACUTE SERVICES.—The plan described in paragraph (1) shall include details for a bundled payment for post acute services (in this section referred to as the “post acute care bundle”), and may include other approaches determined by the Secretary.

(3) POST ACUTE SERVICES.—For purposes of this section, the term “post acute services” means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, critical access hospitals, home health agencies, and other services determined appropriate by the Secretary.

(b) DETAILS.—The plan described in subsection (a)(1) shall include consideration of the following issues:

(1) The nature of payments under a post acute care bundle, including the type of post acute care provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians’ services should be included in the bundle, and the method covered by the bundle.

(2) Whether the payment should be consolidated with the payment under the inpatient prospective system under section 1886 of the Social Security Act (as added by section (b) and other issues that the Secretary determines are appropriate to develop such plan required in this section; and

(3) Whether patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Budget Control Act of 2011.

(c) CONSIDERATION.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies and demonstrations that the Secretary determines appropriate.

(d) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute care service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians; and

(C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop such plan required in this section; and

(2) EXPENDED DATA COLLECTION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(e) PUBLIC REPORTS.—

(1) INTERIM REPORTS.—The Secretary shall issue interim public reports to the extent the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than the date that is three years after the date of the enactment of this Act, the Secretary shall issue a final report, including an analysis of issues described in subsection (a)(1), the issues described in subsection (b), and impact analyses as the Secretary determines appropriate.

(f) CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act is amended by inserting after section 1866C the following new section:

“CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.

“SEC. 1866D. (a) CONVERSION AND EXPANSION.—

(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall—

(A) convert the acute care episode demonstration program under section 1866C to a pilot program; and

(B) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.

(2) BUNDLED PAYMENT INCLUSIONS.—

(A) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

(i) hospitals and post-acute care providers;
skilled nursing facilities (as defined in section 1886(d)(1)(B)(iv)(I)), and long-term care hospitals (as defined in section 1886(d)(1)(B)(ii)), provide inpatient rehabilitation hospital services rendered in physicians' offices, other than those provided under the pilot program.

(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.

(2) CONFORMING AMENDMENT.—Section 1866G(b) of the Social Security Act (42 U.S.C. 1395cc–2(b)) is amended by striking "the Secretary" and inserting "Subject to section 1866D, the Secretary.".

SEC. 1155. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395f(b)(3)(B)(i)) is amended—

(1) in subclause (IV), by striking "and"; and

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

"(v) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;"

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395f(b)(3)(B)) is amended—

(1) in clause (iv), by striking "insofar as"; and

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

"(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.".
in the report the Commission’s conclusions and recommendations, if appropriate, regarding each of the issues described in paragraphs (1), (2) and (3) of such subsection.

SEC. 1155B. ASSIGNMENT OF HOME HEALTH AGENT TO PROVIDE THE MOST APPROPRIATE SKILLED SERVICE TO MAKE THE INITIAL ASSESSMENT VISIT UNDER A MEDICARE HOME HEALTH PLAN OF CARE FOR REHABILITATION CASES.

(a) In General.—Notwithstanding section 1866 in effect on such date.

(b) Rule of Construction.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act but who does not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

(b) Rule of Construction.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act but who does not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

(b) Rule of Construction.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act but who does not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE PROHIBITION OF CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) In General.—Section 1877 of the Social Security Act (42 U.S.C. 1395n) is amended—

(1) in subsection (d)(2)—

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

(B) in subparagraph (B), by striking the period at the end and inserting “; and”; and

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

“(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).”;

(2) subsection (d)(3)—

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

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

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

“(D) the hospital meets the requirements described in subsection (1)(k).”;

(3) by amending subsection (f) to read as follows:

“(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Each entity providing care (or services for which payment may be made under this title) shall provide the Secretary with the information concerning the entity’s ownership, investment, and compensation arrangements, including—

(A) the covered items and services provided by the entity, and

(B) the names and unique physician identifiers of all physician owners or investors in any ownership or investment interest (as described in subsection (a)(2)(A), or with a compensation arrangement (as described in subsection (a)(2)(B)) that the entity or any other persons and entities in the community in the hospital’s service area have made or have been made when the hospital has not participated in the arrangement.

(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (1)(k), the hospital shall—

(A) submit to the Secretary an initial report, and periodically updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

(B) require that any referring physician owner or investor discloses to the individual referred to and to the Secretary the identity of the individual to make a meaningful decision regarding the receipt of services, as determined by the Secretary, or any other provision of law, a patient or a physician owner or investor, applicable, of such referring physician in the hospital;

(C) disclose the fact that the hospital is partially or wholly owned by or one more physicians or has one or more physician investors—

(1) on any public website for the hospital; and

(2) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health recipients furnished services outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.

(4) by amending subsection (g)(5) to read as follows:

“(g) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty under paragraph (4) of section 1128A (other than the first sentence of subsection (f)).

(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (1)(b) or (A) of subsection (f) is subject to civil money penalties of not more than $10,000 for each day for which reporting is required to have been made.

(C) APPLICATION.—The provisions of section 1128A(a) (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”;

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

“(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERAL PROHIBITION.—

(A) PROVIDER AGREEMENT.—The hospital had—

(1) physician ownership or investment on January 1, 2009; and

(2) a provider agreement under section 1866 in effect on such date.

(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total financial interest of the physician owners or investors held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

(2) In the case where the hospital has not participated in any arrangement with a physician owner or investor, applicable, of such referring physician in the hospital;

(1) Any ownership or investment interests that the hospital offers to a physician are in any form that are not directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(2) The hospital does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

(3) The hospital does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor in the hospital.

(vii) Patient Safety.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to provide such services for medical emergencies; and

(1) provide assessment and initial treatment for medical emergencies; and

(2) if the hospital lacks additional capacity required to treat or group any involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

(B) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

(A) PROCESSES.—The Secretary shall establish and implement a process under which a hospital may apply for an exception from the requirement under paragraph (1)(C).

(B) LIMITATION.—The process under clause (i) shall provide persons and entities in the community in

November 7, 2009
which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) Timing for Implementation.—The Secretary may implement the process described in subparagraph (A) on the date that is one month after the promulgation of regulations described in clause (iv).

(iv) Regulations.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations implementing the process described in clause (i). The Secretary may issue such regulations as interim final regulations.

(B) Special Rule for a High Medicaid Facility.—A hospital described in this subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

(C) Permitted Increase.—

(i) In general.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application for and the implementation of the most recent increase under such an exception).

(ii) Frequency.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, or beds of a hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

(iii) Baseline Number of Operating Rooms, Procedure Rooms, or Beds.—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, or beds’ means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

(D) Increase Limited to Facilities on the Main Campus of the Hospital.—Any increase in the number of operating rooms, procedure rooms, or beds of a hospital pursuant to this paragraph may only occur in facilities on the main campus of the hospital.

(E) Approval of an Increase in Facility Capacity.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital described in subparagraph (F) or a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(iii) that does not discriminate against beneficiaries of Federal health care programs for purposes of furnishing services at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average occupancy in the State is estimated to be less than the national average bed capacity;

(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

(vi) that meets the conditions as determined by the Secretary.

(F) Special Rule for a High Medicaid Facility.—A hospital described in this subparagraph is a hospital that—

(i) with respect to each of the 3 most recent cost reporting periods for which data are available, inpatient hospital admissions exceed by 25 percent the annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX that is determined by the Secretary in consultation with the Health Care Financing Administration with respect to such admissions for any other hospital located in a county in which the hospital is located; and

(ii) satisfies the conditions described in clauses (iii) and (vi) of subparagraph (E).

(G) Procedure Rooms.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for those rooms to the extent such rooms are used for treatment of patients who do not require hospitalization), catheterization laboratories, angiographies, angiograms, and endoscopies (as the Secretary determines to be appropriate).

(H) Publication of Final Decisions.—Not later than the 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Internet website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

(i) Limitation on Review.—There shall be no administrative or judicial review under section 1869, section 1787, or otherwise of the exception process under this paragraph, including the establishment of such process, and any determination made under such process.

(3) Physician Owner or Investor Defined.—For purposes of this subsection and subsection (f)(2), the term ‘physician owner or investor’ means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

(4) Patient Safety Requirement.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits patients who do not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

(A) the hospital shall disclose such fact to the patient; and

(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

(5) Clarification.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital’s provider agreement if the hospital is not in compliance with regulations pursuant to section 1886(a).

(b) Verifying Compliance.—The Secretary of Health and Human Services shall establish policies and procedures to verify compliance with the requirements described in subsections (1)(d) and (4) of section 1877 of the Social Security Act, as added by subsection (a)(5). The Secretary may use an independent review entity to verify compliance with such requirements.

(c) Implementation.—

(1) Funding.—For purposes of carrying out the requirements described in subsection (a) and the provisions of subsection (b), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, the Secretary shall make available to the Centers for Medicare & Medicaid Services Program Management Account $5,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this paragraph for a fiscal year shall be unavailable unless appropriated under this paragraph.

(2) Administration.—Chapter 33 of title 44, United States Code, shall not apply to the amendments made by subsection (a) and the amendments made by this section.

SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC ADJUSTMENT FACTORS UNDER MEDICARE.

(a) In General.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive empirical study, and provide recommendations as appropriate, on the accuracy of the geographic adjustment factors established under sections 1866(d)(3)(E) and 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)).

(b) Matters Included.—Such study shall include an evaluation and assessment of the following:

(1) The effect of the adjustment factors on the level and distribution of the health care workforce and resources, including—

(A) recruitment and retention that takes into account workforce mobility between urban and rural areas;

(B) ability of hospitals and other facilities to maintain an adequate and skilled workforce; and

(C) patient access to providers and needed medical technologies.

(2) The effect of the adjustment factors on payment rates for health care quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(c) Evaluation.—Such study shall, within the context of the United States health care marketplace, evaluate and consider the following:

(1) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(2) The effect of the adjustment factors on payment rates for health care quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(d) Report.—The contract under subsection (a) shall provide for the Institute of Medicine to submit, not later than 1 year after the date of the enactment of this Act, to the Secretary and the Congress a report containing results and recommendations of the study conducted under this section.

(e) Funding.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO ADDRESS GEOGRAPHIC INEQUITIES.

(a) Revision of Medicare Payment Systems.—Taking into account the recommendations described in the report under section 1157, and notwithstanding the geographic adjustments that would otherwise apply under section 1840(e) and section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E), the Secretary of Health and Human Services shall include in proposed rules applicable to the provisions of sections 1840(e) and 1886(d) of such Act, respectively, proposals described in the report under section 1157 to revise the geographic adjustment factors used in such systems. Such proposals'
rules shall be contained in the next rule-making cycle following the submission to the Secretary of the report described in section 1157.

(b) Payment Adjustments.—

(1) Funding for Improvements.—For years before 2014, the Secretary shall ensure that the adjustments resulting from the implementation of the provisions of this section, as estimated by the Secretary, do not exceed $8,000,000,000, and do not exceed half of such amount in any payment year.

(2) Hold Harmless.—In carrying out this subsection—

(A) for payment years before 2014, the Secretary shall implement the geographic adjustment in a manner that does not result in any net change in aggregate expenditures under title XVIII of the Social Security Act from the amount of such expenditures that the Secretary estimates would have occurred if no geographic adjustment had occurred; and

(B) for payment years beginning with 2014, the Secretary shall implement the geographic adjustment by which—

(1) an evaluation of the extent to which variations in spending are correlated with insurance status, variations in the distribution of health care resources, health care outcomes, and consensus-based measures of health care quality;

(2) an evaluation of the extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary variations make that could be characterized as different from the best available medical evidence;

(3) an evaluation of the extent to which variation can be explained by patient preferences and patient compliance with treatment protocols.

(3) Medicare Improvement Fund.—

(A) the period beginning with fiscal year 2014 or a subsequent fiscal year

(B) the maximum amount of funds available with respect to services furnished in any one payment year.

(4) Additional Considerations.—The Institute shall evaluate the extent to which geographic variation cannot be explained by empirical evidence.

(5) Medicare beneficiaries, An evaluation of the extent to which variations in spending are correlated with insurance status prior to enrollment in the Medicare program under title XVIII of the Social Security Act, and institutionalization status; whether beneficiaries are enrolled in fee-for-service Medicare or Medicare Advantage.

(6) An evaluation of the extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary variations make that could be characterized as different from the best available medical evidence.

(7) An evaluation of the extent to which variation can be explained by patient preferences and patient compliance with treatment protocols.

(8) An evaluation of the extent to which variation can be explained by patient preferences and patient compliance with treatment protocols.

(c) Medicare Improvement Fund.—

(1) Amounts in the Medicare Improvement Fund under section 1898 of the Social Security Act (42 U.S.C. 1395iI(bb)) shall be available to the Secretary to make changes to the geographic adjustments factors as described in subsections (a) and (b) with respect to services furnished before January 1, 2014. No more than one-half of such amounts shall be available with respect to services furnished in any one payment year.

(2) Section 1898(b) of the Social Security Act (42 U.S.C. 1395IvI(b)) is amended—

(A) by adding paragraph (1)(A) to read as follows:

"(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and";

and

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

"(5) Adjustment for Underfunding.—For fiscal year 2014 or a subsequent fiscal year specified by the Secretary, the amount available to the fund under subsection (a) shall be increased by the Secretary's estimate of the amount (based on data on actual expenditures) which—

(A) the additional expenditures resulting from the implementation of subsection (a) of section 1158 of the Affordable Health Care for America Act for the period before fiscal year 2014, is less than

(B) the maximum amount of funds available under subsection (a) of such section for funding for such expenditures;".

SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) In General.—The Secretary of Health and Human Services (in this section and the succeeding sections, referred to as the "Secretary") shall enter into an agreement with the Institute of Medicine of the National Academies (referred to in this section as the "Institute") to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending for items and services under parts A and B of title XVIII of the Social Security Act or Medicaid under title XIX of the Social Security Act.

(b) Study.—In so doing, the Institute shall consider the adoption of a value index based on a composite of appropriate measures that would adjust provider payments on a regional or provider-level basis. If the Institute finds that application of such a value index is appropriate, it shall make specific recommendations on how such an index would be designed and implemented. In so doing, it should identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how payments and spending under such title would be affected by such an index.

(c) Appropriate Use of Evidence.—The Secretary shall consider the experience of government and community-based programs that promote high-value care.

(d) Reports.—

(1) Not later than April 15, 2011, the Institute shall submit to the Secretary and each House of Congress a report containing findings and recommendations of the study conducted under this section.

(2) Following submission of the report under paragraph (1), the Institute shall use the data collected and analyzed in this section to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. Such reports shall include a comparison to the Institute's findings and recommendations regarding the Medicare program. Such reports, and any recommendations, would not be subject to the procedures outlined in section 1160.

(e) High-Value Care Defined.—For purposes of this section, the term "high-value care" means the efficient delivery of high quality, evidence-based, patient-centered care.

(f) Appropriations.—There is appropriated from amounts in the general fund of the Treasury not otherwise appropriated $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDIACRE PAYMENTS TO PROMOTE HIGH VALUE HEALTH CARE.

(a) Preparation and Submission of Implementation Plans.—

(1) Final Implementation Plan.—Not later than 240 days after the date of the receipt by the Secretary and each House of Congress of the report under section 1159(e)(1), the Secretary shall submit to each such house a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of the Social Security Act (which may include payment for inpatient and outpatient hospital services for services furnished in PPS and PPS-exempt hospitals, physicians' services, hospice services, home health services, hospice care, clinical laboratory services, durable medical equipment, and other items and services, but which shall not include in-patient, payments for graduate medical education, disproportionate share payments, and health

implementation plan.—
Not later than 90 days after the date the
Institute of Medicine submits to each House of
Congress the report under section 1198(a)(1), the
Secretary shall submit to each House of
Congress a preliminary version of the imple-
mation plan provided for under paragraph
(1)(A).
(3) NO INCREASE IN BUDGET EXPENDITURES.—
The Secretary shall include with the submis-
sion of the final implementation plan under
paragraph (1) a certification by the Chief Ac-
tuary Officer of the Medicare Payment Advi-
sory Board that a preliminary version which a
Schottky-Baer Services that over the initial 10-year period
in which the plan is implemented, the aggre-
gate level of net expenditures under the Med-
care program under title XVIII of the Social
Security Act will not exceed the aggre-
gate level of such expenditures that would
have occurred if the plan were not imple-
mented.

(4) WAIVERS REQUIRED.—To the extent the
final implementation plan under paragraph
(1) proposes changes that are not otherwise
permitted under subsection (c), the Secretary
shall specify in the final implementation plan under
paragraph (1) a certification by the Chief Ac-
tuary Officer of the Medicare Payment Advi-
sory Board that a preliminary version which a
Schottky-Baer Services that over the initial 10-year period
in which the plan is implemented, the aggre-
gate level of net expenditures under the Med-
care program under title XVIII of the Social
Security Act will not exceed the aggre-
gate level of such expenditures that would
have occurred if the plan were not imple-
mented.

(5) ASSESSMENT OF IMPACT.—In addition,
both the preliminary and final implementa-
tion plans under this subsection shall in-
dicate a detailed assessment of the effects of
the proposed payment changes by provider or
supplier type and State relative to the pay-
ments that would otherwise apply.

(b) DURATION.—
Not later than 45 days after the date the prelimi-
nary implementation plan is received by
each House of Congress under subsection
(a)(1), and the Comptroller General of the
United States shall each evaluate such plan
and submit to each House of Congress a re-
port containing its analysis and rec-
mendations regarding implementation of
the plan, including an analysis of the effects of
the proposed changes in the plan on pay-
ments and projected spending.

(c) IMPLEMENTATION.—
(1) IN GENERAL.—The Secretary shall in-
clude in its final implementation plan a proposal
for the next rulemaking cycle beginning after the
Congressional action deadline, appropriate
proposals to revise payments under title
XVIII of the Social Security Act in accord-
ance with the final implementation plan sub-
mitted under subsection (a)(1), and the
waiver
specified in subsection (a)(4) to the
extent that such plan is effective, unless a joint resolution (described
in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such
deadline. If the resolution is enacted before the
deadline, the Secretary is not authorized to implement
such plan and the waiver authority provided under
subsection (a)(4) shall no longer be ef-
fective.

(2) CONGRESSIONAL ACTION DEADLINE.—For
purposes of this section, the term “Congres-
sional action deadline” means, with respect to
such a resolution introduced under paragraph
(1) is referred to as the “responsible House,” and, if the re-

(3) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—
(A) REPORTING AND DISCHARGE.—Any com-
mittee of the House of Representatives to which
such a joint resolution is referred under
paragraph (1) is referred shall report such
joint resolution to the House not later than
5 legislative days after the applicable date
of introduction of the joint resolution. If
the committee reports such joint resolution in
accordance with the procedures of the House
of Representatives, the joint resolution
shall be placed on the calendar.

(C) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph and the pre-
ceding paragraphs are enacted by Congress—

(A) REPORTING AND DISCHARGE.—Any com-
mittee to which such a joint resolution is referred under paragraph
(1) is referred shall report such joint resolution to the appropriate House, and the other House,
within 5 legislative days after the applicable date
of introduction of the joint resolution. If the committee reports such joint resolution in
accordance with the procedures of the House
of Representatives, the joint resolution
shall be placed on the calendar.

(B) PROCEEDING TO CONSIDERATION.—A mo-
tion in the Senate to proceed to the consid-
eration of a joint resolution shall be carried
over until the Senate disposes of other business.

(3) CONSIDERATION.—
(C) CONSIDERATION.—
(B) TREATMENT OF COMPANION MEASURES.—In
the case of a joint resolution introduced under paragraph
(1) of this section, the term “Companion
measures” means, with respect to such joint
resolution, the joint resolutions introduced
by the other House and the House of
Representatives, as the case may be.

(4) RULES RELATING TO SENATE AND HOUSE OF REPRESENTATIVES.

(A) GENERAL.—A joint resolution introduced
under paragraph (1) shall be referred to
the Committee on the Budget of the House
of Representatives, and the Committee on the
Budget of the Senate, and the House
and Senate shall each take such joint
resolution under its own rules.

(B) TREATMENT OF COMPANION MEASURES.—In
the event that the House of Representatives
adopts a joint resolution and the Senate
adopts a joint resolution, both House
and Senate shall each take such joint
resolution under its own rules, with con-
sideration of the joint resolution by
the Senate taking place after such joint
resolution is reported to the Senate
by the appropriate committee in the House
of Representatives.

(5) CONSIDERATION.—The joint resolution shall be
considered in the Senate as provided in the
appropriate rules of the Senate, and pending
consideration of such joint resolution, the
definitive action shall be on the joint
resolution, and not on the Senate
consideration of the joint resolution by
the House of Representatives.

(6) CONSIDERATION.—The joint resolution shall be
considered in the House of Representatives
as provided in the appropriate rules of
the House, and pending consideration of
such joint resolution, the definitive action
shall be on the joint resolution, and not
on the House consideration of the joint
resolution by the Senate.
rules only to the extent that it is inconsistent with such rules; and

(ii) with full recognition of the constitutional right of either House to change the rules as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(5) References in this section:

(A) JOINT RESOLUTION.—The term ‘‘joint resolution’’ means only a joint resolution—

(i) which does not have a preamble; and

(ii) the title of which is as follows: ‘‘Joint resolution disapproving a Medicare final implementation plan of the Secretary of Health and Human Services submitted under section 110(a) of the Affordable Health Care for America Act’’; and

(3) The sole matter after the resolving clause of which is as follows: ‘‘That the Congress disapproves the final implementation plan of the Secretary of Health and Human Services transmitted to the Congress on …’, the blank space being filled with the appropriate date.

(B) LEGISLATIVE DAY.—The term ‘‘legislative day’’ means any calendar day excluding any day on which that House was not in session.

(6) BUDGETARY TREATMENT.—For the purposes of consideration of a joint resolution, the Committees of Representatives and Senate Committees on the Budget shall exclude from the evaluation of the budgetary effects of the measure, any such effects that may attributable to disapproving a Medicare final implementation plan of the Secretary submitted under subsection (a).

 SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS; QUALITY BONUS PAYMENTS.

(a) PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1883 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ‘‘beginning with 2007’’ and inserting ‘‘for 2008, 2009, and 2010’’; and

(B) by inserting after ‘‘(k)(1)’’ the following: ‘‘(l) BONUS PAYMENTS.’’;

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

‘‘(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year specified by the Secretary, the blended benchmark amount under subsection (n)(2) shall be—

(A) for 2011, by 1.5 percent; and

(B) for 2012, by 3.0 percent.

(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

(A) QUALIFYING PLAN.—The term ‘‘qualifying plan’’ means, for a year and subject to clause (ii) of paragraph (4), a plan that, in a preceding year specified by the Secretary; and

(B) QUALIFYING COUNTY.—The term ‘‘qualifying county’’ means, for a year, a county—

(i) that ranked within the lowest third of counties in the amount specified in subsection (n)(2) for a year specified by the Secretary; and

(ii) for which, as of June of a year specified by the Secretary, the Medicare Advantage eligible individuals residing in the county at least 20 percent of such individuals were enrolled in Medicare Advantage plans.

(b) QUALITY BONUS PAYMENTS.—Section 1883 of the Social Security Act (42 U.S.C. 1395w–23; as amended by subsection (a), is amended—

(1) in subsection (j), by inserting ‘‘subject to subsections (k) and (l)’’ after ‘‘For purposes of this part,’’; and

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

‘‘(k) QUALITY BASED PAYMENT ADJUSTMENT.—(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year specified by the Secretary, the blended benchmark amount under subsection (n)(2) shall be increased—

(A) for 2011, by 1.5 percent; and

(B) for 2012, by 3.0 percent.

(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

(A) QUALIFYING PLAN.—The term ‘‘qualifying plan’’ means, for a year and subject to clause (ii) of paragraph (4), a plan that, in a preceding year specified by the Secretary;

(B) QUALIFYING COUNTY.—The term ‘‘qualifying county’’ means, for a year, a county—

(i) that ranked within the lowest third of counties in the amount specified in subsection (n)(2) for a year specified by the Secretary; and

(ii) for which, as of June of a year specified by the Secretary, the Medicare Advantage eligible individuals residing in the county at least 20 percent of such individuals were enrolled in Medicare Advantage plans.

(c) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of quality performance data described in this paragraph (in order to determine a quality performance score under this paragraph) in such time and manner as the Secretary shall specify.

(d) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall publish in the Federal Register such measure for a period of public comment on such measure.

(b) ADVANCE PAYMENT.—For payments for years specified by the Secretary, the Medicare Advantage quality performance score for a Medicare Advantage plan based on a blend of the measures specified in clause (i) and the measures described in clause (ii) and selected under clause (iii).

(c) USE OF QUALITY OUTCOMES MEASURES.—For payments for years specified by the Secretary, each Medicare Advantage plan shall exclude from the evaluation of the quality performance score for a Medicare Advantage plan if the Secretary has identified deficiencies in the plan’s compliance with rules for Medicare Advantage plans under this part.

(c) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of quality performance data described in this paragraph in such time and manner as the Secretary shall specify.

(d) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall publish in the Federal Register such measure for a period of public comment on such measure.

SEC. 1162. AUTHORITY FOR SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.

(a) GENERAL.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan’s compliance with rules for Medicare Advantage plans under this part.
SEC. 1165. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) 2-Week Processing Period for Annual Enrollment Period (AEP).—Paragraph (3)(B) of section 1852(a) of the Social Security Act (42 U.S.C. 1395w–22(a)) is amended—

(1) by striking “and” at the end of clause (iii); and

(2) in clause (iv)—

(A) by striking “and succeeding years” and inserting “, 2008, 2009, and 2010”; and

(B) by striking the period at the end and inserting “;”;

and

(c) MA Regional Plan Stabilization Fund. (A) IN GENERAL.—The Administrator of the Health Care Financing Administration shall transmit a report to the Congress, in a form and manner specified by the Secretary, taking into account the potential effects of the regional average of Medicare Part B payments on MA regional plan stabilization funds, including any implications for program operations and the potential effects of calculating Medicare Advantage payments on MA regional plan stabilization funds.

(B) DATA FOR 2010 AND 2011.—The data submitted under paragraph (A) with respect to the fiscal year beginning on October 1, 2010, and ending on December 31, 2011, shall be submitted in a form and manner specified by the Administrator, based on the following:

(1) the quality of care received by Medicare Advantage enrollees;

(2) the methodologies used to develop the regional average of Medicare Part B payments;

(3) the predictive accuracy of the regional average of Medicare Part B payments for MA regional plans.

(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—

(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year, guidelines for the regional average of Medicare Part B payments, taking into account the potential effects of calculating Medicare Advantage payments on MA regional plan stabilization funds.

(2) DATA FOR 2010 AND 2011.—The data submitted under paragraph (A) with respect to the fiscal year beginning on October 1, 2010, and ending on December 31, 2011, shall be submitted in a form and manner specified by the Administrator, taking into account the regional average of Medicare Part B payments.

(3) DEVELOPMENT OF DATA REPORTING STANDARDS. —

(A) IN GENERAL.—The Secretary shall develop, implement, and maintain data reporting standards for the regional average of Medicare Part B payments, taking into account the potential effects of calculating Medicare Advantage payments on MA regional plan stabilization funds. The data submitted under paragraph (A) with respect to the fiscal year beginning on October 1, 2010, and ending on December 31, 2011, shall be submitted in a form and manner specified by the Administrator, taking into account the regional average of Medicare Part B payments.

(B) CONSULTATION.—The Secretary shall consult, in a form and manner specified by the Administrator, with professional organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions developed under paragraph (3).

(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under paragraph (A) relating to the regional average of Medicare Part B payments for the fiscal year beginning on October 1, 2010, and ending on December 31, 2011, shall be submitted in a form and manner specified by the Administrator, taking into account the regional average of Medicare Part B payments.

(D) IMPLEMENTATION.—Not later than January 1, 2012, the Secretary shall submit to the Congress, in a form and manner specified by the Administrator, a report describing the methodology used to develop the regional average of Medicare Part B payments, taking into account the potential effects of calculating Medicare Advantage payments on MA regional plan stabilization funds.
the following new paragraph:

"(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least 85—

"(A) the Secretary shall require the Medicare Advantage organization offering the plan to give enrollees a rebate (in the second succeeding contract year) of premium amounts attributable to such plan year; or

"(B) the Secretary shall permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

"(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

SECT. 1174. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after "section 1858(o)" the following: 

", and data submitted with respect to risk adjustment under section 1858(a)(3)",.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

"(1) IN GENERAL.—Section 1857(e) of such Act, as amended by section 173, is amended by adding at the end the following new paragraph:

"(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

"(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall include terms that inform the organization of the provisions in subsection (d). 

"(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.

"(2) APPLICABILITY UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2011.

SECT. 1175. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(6) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

"(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid by an MA organization under this subsection.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

"(3) EFFECTIVE DATE.—The amendments made by this section shall apply to bids for contract years beginning on or after January 1, 2011.

SECT. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN ENROLLMENT PERIOD OF DUAL ELIGIBLE INDIVIDUALS SERVING AS DUAL ELIGIBLE MA SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new subparagraph:

"(A) The plan does not enroll an individual on or after January 1, 2011, other than—

"(i) during an annual, coordinated open enrollment period; or

"(ii) during a special election period consisting of the period for which the individual has a chronic condition that qualifies the individual as dual eligible under section 1857(b)(4)(B)(iv) for such plan year, beginning on the date on which the individual enrolls in such a plan on the basis of such condition.

If an individual is enrolled in such a plan on the basis of a chronic condition, the plan must be the one that is most eligible for another such plan on the basis of another chronic condition, the other plan may enroll the individual on the basis of such other chronic condition beginning on the date of such special enrollment period described in clause (ii). An individual is eligible to apply such clause only once on the basis of any specific chronic condition.

SECT. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS PLANS TO RESTRICT ENROLLMENT; SERVICE AREA MORATORIUM FOR CERTAIN SNPS.

(a) IN GENERAL.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking "January 1, 2011" and inserting "January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the Affordable Health Care for America Act)"

(b) EXTENSION OF CERTAIN PLANS.—

"(1) PLANS DESCRIBED.—For purposes of Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), a plan described in this paragraph is a Medicare Advantage dual eligible special needs plan that—

"(A) is a Medicare Advantage dual eligible special needs plan that—

"(i) does not sponsor a Medicare Advantage organization, as of the date enactment of the Affordable Health Care for America Act, has participated in the "Demonstrations Serving Those Dually-Eligible for Medicare and Medicaid" under the Medicare program; and

"(B) that has been approved by the Centers for Medicare & Medicaid Services as a dual eligible special needs plan and that offers integrated Medicare and Medicaid services under a contract with the State Medicaid agency.

"(2) ANALYSIS; REPORT.—

"(A) ANALYSIS.—The Secretary of Health and Human Services shall enter into a contract with an independent health services evaluation organization, for an analysis of the plans described in paragraph (1) with regard to the impact of such plans on cost, quality of care, patient satisfaction, and other subjects specified by the Secretary. Such report shall also identify statutory changes needed to simplify access to needed services, improve coordination of benefits and services and ensure protection for dual eligibles as appropriate.

"(B) REPORT.—Not later than December 31, 2011, the Secretary shall submit to the Congress a report on the analysis under subparagraph (A) and shall include in such report recommendations with regard to the treatment of such plans as the Secretary deems appropriate.
SEC. 1178. EXTENSION OF MEDICARE SENIOR HOUSING PLANS.

Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

"(g) Special Rules for Senior Housing Facility Plan Described.—For purposes of this subsection—

"(i) in general.—Notwithstanding any other provision of this Part, in the case of a Medicare Advantage senior housing facility plan described in paragraph (2) and for periods before January 1, 2013,

"(II) the term 'covered part D drug' does not include a covered part D drug that is administered on or after January 1, 2011, in this Part, referred to in subparagraph (A) and the out-of-pocket threshold for a year to the extent necessary to ensure that the sum of the initial coverage limit described in subparagraph (A) (as defined in clause (iv)) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.

"(E) RELATION TO AAAHC TRANSITIONAL INCREASE.—Except as otherwise specifically provided herein, this paragraph shall be applied as if no increase had been made in the initial coverage limit under paragraph (7)."

"(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—

"(i) in general.—For a year beginning with 2011, subject to clause (ii), the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by the cumulative OPT phase-in percentage (as defined in clause (iii) for the year) of the out-of-pocket gap amount for the year multiplied by 1.75.

"(ii) Maintenance.—The Secretary shall adjust the annual out-of-pocket threshold for a year pursuant to the extent necessary to ensure that the sum of the initial coverage limit described in subparagraph (A) and the out-of-pocket threshold for purposes of applying paragraph (D), as determined for the year pursuant to the provisions of this paragraph for such year, does not exceed such sum that would have applied if this paragraph did not apply.

"(iii) Cumulative OPT Phase-in Percentage.—For purposes of this paragraph, subject to subparagraph (B)(iii)(II), the term 'cumulative OPT phase-in percentage' means for a year the sum of the annual OPT phase-in percentage (as defined in clause (iv) for the year and the annual OPT phase-in percentage for each previous year beginning with 2011.

"(iv) Annual OPT Phase-in Percentage.—For purposes of this paragraph, the term 'annual OPT phase-in percentage' means—

"(I) for 2011, 0 percent;

"(II) for 2012, 2013, and 2014, 4.5 percent;

"(III) for 2015 and 2016, 6 percent;

"(IV) for 2017, 7.5 percent;

"(V) for 2018 and 2019, 8 percent.

"(D) Out-of-Pocket Gap Amount.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

"(I) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

"(II) the sum of—

"(a) the annual deductible under paragraph (1) for the year; and

"(b) ⅔ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.

"(E) Relation to AAHC Transitional Increase.—Except as otherwise specifically provided herein, this paragraph shall be applied as if no increase had been made in the initial coverage limit under paragraph (7)."

"(C) PRESERVATION OF INCREASED BOUNTY.—Except as otherwise specifically provided herein, this paragraph shall be interpreted as if no increase had been made in the initial coverage limit under paragraph (7)."

"(II) For purposes of this paragraph, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

"(B) 2010 PLAN YEAR REQUIREMENT.—Any drug or biological product manufactured by a manufacturer that declines to enter into a rebate agreement described in paragraph (2) for the period beginning on January 1, 2010, and ending on December 31, 2010, shall not be included as a 'covered part D drug' for the purposes of this subsection.
manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2009, in the amount specified in paragraph (3) for and for each dosage form of the drug dispensed by the manufacturer after December 31, 2009, except that no such rebate shall be paid to a MA organization under part C for such period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–13 through 1860D–15(b), respectively. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1557(h)(3), or 30 days after the receipt of information under subparagraph (D) of paragraph (3), as determined by the Secretary.

Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement relating to compliance, penalties, and program evaluations, investigations, and audits that are similar to the terms and conditions for rebate agreements under paragraphs (3) and (4) of section 1927(b).

(3) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by the manufacturer after December 31, 2009, to a MA organization under part C for the rebate period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively; and

(ii) the amount (if any) by which—

(I) the Medicaid rebate amount (as defined in subparagraph (C)) shall apply to rebate agreements entered into by the Secretary for adjusting manufacturer rebate payments not later than 3 months after the date that manufacturers receive the information collected under section 1860D–12(b)(7)(B).

(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (D)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

(5) OTHER REBATE ELIGIBILITY CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

(A) REBATE ELIGIBLE INDIVIDUAL.—The term ‘rebate eligible individual’—

(i) means a full-benefit dual eligible individual (as defined in section 385(c)(6)); and

(ii) to a manufacturer—

(A)(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(c) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

(ii) in the case of any other covered outpatient drug—

(A)(ii) the term ‘rebate amount’ means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan, of—

(i) the product, for each such sponsor or organization, of—

(1) the sum of rebates, discounts, or other payments (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to rebate eligible Medicare drug plan enrollees and MA–PD enrollees who are not rebate eligible individuals; and

(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plan of the PDP sponsor administered under the MA–PD plan managed by the MA organization; divided by

(i) the number of the units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plan of the PDP sponsor administered under the MA–PD plan managed by the MA organization; and

(ii) the number of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA organizations.

(3)(A) USE OF ESTIMATES.—The Secretary may establish a methodology for estimating the average Medicare drug program rebate eligible rebate amounts for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates required under this subsection by the Secretary to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall submit a satisfactory success for adjusting manufacturer rebate payments not later than 3 months after the date that manufacturers receive the information collected under section 1860D–12(b)(7)(B).

(B) REPORT FORM AND CONTENTS.—Notwithstanding the provisions of subparagraph (D) of section 1927(b)(3), the Secretary shall require such reports to be consistent with any standards established by the Secretary.

(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of each report required under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

(D) CONFIDENTIALITY OF INFORMATION.—The Secretary may use information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

(i) that any reference to this section in clauses (i) or (ii), (iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program rebate eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period;

Such report shall be in a form consistent with any standard reporting format established by the Secretary.

(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

(ii) that knowingly (as defined in section 1128A(a)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to any other penalties as may be prescribed by law.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner that such provisions apply to a penalty or proceeding under section 1128A(a)."
SEC. 1182. DISCOUNTS FOR CERTAIN QUALIFYING DRUGS IN ORIGINAL COVERAGE GAP.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102), as amended by section 1181, is amended—

(1) in subsection (b)(4)(C)(ii), by inserting “subject to subsection (g)(2)(C),” after “(ii)”; and

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

“(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

“(1) IN GENERAL.—In this part, the term ‘covered part D drug’ does not include any drug or biological product that is manufactured by a manufacturer that has not entered into an agreement with all qualifying drugs (as defined in paragraph (5)(C)) at a discount agreement described in paragraph (2).

“(2) DISCOUNT AGREEMENT.—

“(A) PERIODIC DISCOUNT.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(C)) of the manufacturer dispensed to a qualifying enrollee after January 1, 2010, insofar as the individual is in the original gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

“(B) QUALIFYING ENROLLEE.—The term ‘qualifying enrollee’ means an individual enrolled under this paragraph to beneficiaries as close as practicable after the point of sale.

“(C) ADDITIONAL TERMS.—In the case of a discount agreement specified in this paragraph for a drug or biological product that—

“(i) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by an any cross-licensed producers or distributors operating under the same terms and conditions for rebate agreements, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1860D–2(b), except that—

“(I) the negotiable price (as defined in section 423.100(e)) of the drug or biological product is equal to the negotiated price (as defined in section 423.100(f)),

“(ii) the discount amount does not exceed 50 percent of the mean of the negotiated prices paid by MA–PD plans for the drug or biological product that is the subject of this agreement.

“(D) REPORTING REQUIREMENT RELATED TO DISCOUNT AGREEMENT.—

“(1) IN GENERAL.—A discount agreement under this paragraph shall require the manufacturer involved to report the terms and conditions for rebate agreements, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1860D–2(b), except that—

“(I) the discount amount does not exceed 50 percent of the mean of the negotiated prices paid by MA–PD plans for the drug or biological product that is the subject of this agreement.

“(2) ADDITIONAL TERMS.—In the case of a discount agreement specified in this paragraph for a drug or biological product that—

“(i) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the same terms and conditions for rebate agreements, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1860D–2(b), except that—

“(I) the mean of the negotiated prices paid by MA–PD plans for the drug or biological product is equal to the mean of the negotiated prices paid by MA–PD plans for the drug or biological product that is the subject of this agreement.

“(ii) the discount amount does not exceed 50 percent of the mean of the negotiated prices paid by MA–PD plans for the drug or biological product that is the subject of this agreement.

“(E) ORIG

“...
(3) by adding at the end the following new clause:

"(ii) Changes in formula only require initiating marketing for a plan year if—(A) a covered part D drug is removed from the formulary by a PDP sponsor or a prescription drug plan (or MA organization of a MA-PD plan) or any other material change to the formulary so as to reduce the amount of the drug under the plan for a plan year shall take effect by a date specified by the Secretary (which shall start the start of marketing activities for the plan year. In addition to any exceptions to the previous sentence to the Secretary, the previous sentence shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management

"(A) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) as a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.

SEC. 1186. NEGOTIATION OF LOWER COVERED PART D DRUG PRICES ON BEHALF OF MEDICARE BENEFICIARIES.

(a) NEGOTIATION BY SECRETARY.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (1)(A).

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

SEC. 1186. FREE GENERIC FILL.

(a) IN GENERAL.—Section 1228A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (C), by striking “1996” and all that follows and inserting “1996;”;

(2) in the first subparagraph (B), by striking “prohibited” and all that follows and inserting “prohibited”;

(3) by redesignating the second subparagraph (D) as a subparagraph (E) and by striking the period at the end of such subparagraph and inserting “;”;

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

"(F) with regard to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, a reduction in or waiver of the copayment amount under the plan given to an individual to switch to a generic, bioequivalent drug, or biosimilar.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall first apply to PDP sponsors and MA organizations to reduce the quantities of covered part D drugs dispensed to enrollees who are residing in long-term care facilities in order to reduce waste associated with unused medications.

SEC. 1189. REDUCTION OF WASTEFUL DISPENSING.

(a) IN GENERAL.—The Secretary shall establish utilization management techniques, such as daily, weekly, or automated dose dispensing, to apply to PDP sponsors and MA organizations to reduce the quantities of covered part D drugs dispensed to enrollees who are residing in long-term care facilities in order to reduce waste associated with unused prescription drugs.

SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.

(a) ADDITIONAL TELEHEALTH SITE.—

(1) IN GENERAL.—Paragraph (4)(O)(i) of section 1833(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new subclause:

"(JX) A renal dialysis facility.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) IN GENERAL.—The Secretary shall create a Telehealth Advisory Committee (in this section referred to as the ‘Advisory Committee’) to make recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services and HCPCS codes to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

(2) MEMBERSHIP; TERMS.—

(A) Membership.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

(i) 5 shall be practicing physicians;

(ii) 2 shall be practicing non-physician health care practitioners; and

(iii) 2 shall be administrators of telehealth programs.

(B) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—
“(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

(II) give preference to individuals who are currently practicing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

(IV) take into account the recommendations of stakeholders.

(2) MEETINGS.—The members of the Advisory Committee shall meet for such term as the Secretary may specify.

(3) OBJECTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.

(5) FOLLOWING RECOMMENDATIONS.—Section 183(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end thereof the following new clause:

“(I) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1866(c)) when adding or deleting services and (HCPCS Level II) establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.

(6) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) of this subparagraph (A) establishing a limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services) otherwise.

(c) HOSPITAL CREDENTIALING OF TELEMEDICINE PHYSICIANS AND PRACTITIONERS.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x–1) is amended by inserting at the end of such section the following new subsection:

“(2) Section 1861(m)(4) (of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end thereof the following new clause:

“(3) CONSTRUCTION.—This subsection shall not be construed as limiting the ability of the Secretary to issue additional guidance regarding the requirements for the compilation of credentials and privileging requirements.”

(4) DEFINITIONS.—In this subsection:

(A) The term “hospital” has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x) and includes a critical access hospital (as defined in subsection (mm)(1) of such section).

(B) The term “physician” has the meaning given such term in subsection (r) of such section.

(C) The term “practitioner” means a practitioner described in subsection 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

SEC. 1191. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)) is amended—

(1) in subclause (I)—

(A) in the first sentence, by striking “2010” and inserting “2013”; and

(B) in the second sentence, by striking “or 2009” and inserting “, 2009, 2010, or 2011”; and

(2) in subclause (III), by striking “January 1, 2012” and inserting “January 1, 2013”.

SEC. 1195. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.


SEC. 1196. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554) is amended—

(1) in the matter preceding clause (i), by striking “2009” and inserting “2012”.

(2) in subclause (I),—

(A) by striking “or (a)”; and

(B) by striking “51” and inserting “52”.

(3) in subclause (II),—

(A) by striking “the Secretary shall promulgate regulations for the purpose of determining the maximum amount of such payments;” and

(B) by striking “, or (b):” and inserting “or (b);”.

(4) in subclause (III),—

(A) by striking “$10,000, or $10,000, or $10,000, or $10,000, or $10,000, or $10,000.”

(B) by striking the period at the end of such subsection, and inserting a semicolon.

(5) in subclause (IV),—

(A) by striking “before” and inserting “before”; and

(B) by striking “or (b)”."
SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–1(h)(1)(D)(i) of the Social Security Act (42 U.S.C. 1396w–11(h)(1)(D)(i)) is amended—

(1) by striking “INSTITUTIONALIZED INDIVIDUALS.—” and inserting “ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—”;

(2) by striking “In general.—” and inserting “In general.—The term “retroactive LIS enrollment beneficiary” means an individual who—”;

(3) by striking “ELIGIBLE AS A FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL” and inserting “ELIGIBLE AS A FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL”;

(4) by striking “ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—” and inserting “ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—”;

(5) by striking “The term “qualified during such period for the low income subsidy” means, with respect to a retrospective beneficiary, the period if the beneficiary had been both enrolled during the retroactive coverage period of the Medicare prescription drug plan and recognized by such plan as eligible as a full-benefit dual eligible individual” and inserting “The term “qualified during such period for the low income subsidy” means, with respect to a retrospective beneficiary, the period if the beneficiary had been both enrolled during the retroactive coverage period of the Medicare prescription drug plan and recognized by such plan as eligible as a full-benefit dual eligible individual”;

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning on the date on which the plan receives notice from the Secretary that the beneficiary is eligible for assistance described in such subsection;

(c) DISCLOSURES.—The amendments made by paragraph (1) shall apply on January 1, 2011.

SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—

(1) IN GENERAL.—Clause (ii) of section 1860D–1(h)(3)(E) of the Social Security Act (42 U.S.C. 1396w–11(h)(3)(E)) is amended by adding after subparagraph (ii) the following new subparagraph:

“(E) Moratorium on enrollment.—In the case of a retroactive LIS enrollment beneficiary, an individual who was automatically enrolled or automatically enrolled under a prescription drug plan pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract, (i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of title XVIII) and subsequently becomes eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled or automatically enrolled under a prescription drug plan pursuant to a RFP contract described in this section is a contract described in this section is a contract entered into between the Secretary and a qualified drug plan sponsor, or a similar subsequent request for proposals.

(b) EXCEPT FOR BENEFICIARIES ENROLLED IN RFP PLAN.—

(1) IN GENERAL.—In no case shall an individual described in subparagraph (A)(ii) include an individual who is enrolled, pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract.

(c) Definitions.—The term “qualified during such period for the low income subsidy” means—

(I) beginning on the date the individual is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the amount by which—

(A) the costs incurred by such beneficiary during the retroactive coverage period of the plan and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary;

(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1917, or under a waiver under section 1115) the individual would require level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded to be reimbursed under the State plan under title XIX, the eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled or automatically enrolled under a prescription drug plan pursuant to a RFP contract described in this section is a contract described in this section is a contract entered into between the Secretary and a qualified drug plan sponsor, or a similar subsequent request for proposals.

(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1917, or under a waiver under section 1115) the individual would require level of care to be reimbursed under the State plan under title XIX, the eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled or automatically enrolled under a prescription drug plan pursuant to a RFP contract described in this section is a contract described in this section is a contract entered into between the Secretary and a qualified drug plan sponsor, or a similar subsequent request for proposals.

(III) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

(A) the individual shall be permitted to apply on the basis of self-certification of income and resources; and

(B) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except where extraordinary situations as determined by the Commissioner.”;

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning January 1, 2011.

SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIMBURSEMENTS FOR RETROACTIVE LOW INCOME SUBSIDY ENROLLMENT.

(a) IN GENERAL.—In the case of a retroactive LIS enrollment beneficiary who is enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the beneficiary (or any eligible third party) is entitled to reimbursement under section 1860D–2(b)(2) for all amounts through the total amount of expenditures which are attributable to the services, supplies, or items, which the individual is eligible; and

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply on January 1, 2011.

SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(h)(1)(C) of the Social Security Act (42 U.S.C. 1396w–11(h)(1)(C)) is amended by adding after subparagraph (D)(ii) the following new subparagraph:

“(E) in the case of a retroactive LIS enrollment beneficiary, an individual who was automatically enrolled or automatically enrolled under a prescription drug plan pursuant to a RFP contract described in this section is a contract described in this section is a contract entered into between the Secretary and a qualified drug plan sponsor, or a similar subsequent request for proposals.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for contract years beginning with 2012.
SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.

(a) SPECIAL ENROLLMENT PERIOD.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–27(b)(3)(D)) is amended to read as follows:

“(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) to be a subsidy eligible individual,”.

(b) AUTOMATIC ENROLLMENT.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–27(b)(1)) is amended by inserting at the end the following new subparagraph:

“(D) SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the process described in subparagraph (C) to such individual in the same manner as such assignment process applies to a part D eligible individual described in such section (a)(2)(B).

Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined by the Secretary (or in the program under part C of the Social Security Act) who is determined under subparagraph (A) to such individual in the manner described in paragraph (3) of such subparagraph (A) from changing such enrollment.”.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to subsidy determinations made for months beginning with January 2011.

SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO RETIRE AND QUALITY BONUS PAYMENTS IN CALCULATION OF LOW INCOME SUBSIDY BENCHMARK.

(a) IN GENERAL.—Section 1861D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–27(c)(2)(B)(iii)) is amended by inserting before the period the following:

“or” at the end of subparagraph (A) and—

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to subsidy determinations made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

SEC. 1221. ENSURING EFFECTIVE COMMUNICATION.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems to support the use of language services.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such agencies could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare fee schedule relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician’s practice, and beneficiaries cost-sharing.

(F) The extent to which providers under parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make available language services for beneficiaries with limited English proficiency.

(G) The nature and type of language services provided by States under title XIX of the Social Security Act and the extent to which such services could be utilized by beneficiaries and providers under title XVIII of such Act.

(H) The extent to which interpreters and translators providing services to Medicare beneficiaries under title XVIII of such Act are trained or accredited.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in paragraph (2)(A) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services); (B) a non–English language by a bilingual provider or use of an interpreter;

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services through a third party or through contract with external independent contractors or agencies, or both);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

(5) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly known as the “Paperwork Reduction Act”), shall not apply for purposes of carrying out this subsection.

(6) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall provide for the transfer, from the Federal Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $2,000,000 for purposes of carrying out this subsection.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27g(1)) is amended—

(1) by striking “or” at the end of subparagraph (B);

(2) by adding “or” at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new paragraph:

“(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;”.

SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMTED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Not later than 6 months after the date of the completion of the study described in section 1221(a) of this Act, the Secretary, acting through the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration the Secretary shall take into consideration the results of the study conducted under section 1221(a) of this Act and adjust, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are underserved with respect to language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) Eligibility: Provision of Services.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

(A) be a provider of services under part A of title XVIII of the Social Security Act;

(B) a service provider under part B of such title;

(C) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title;

(2) PRIORITIES.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i); (ii) at least 6 grants to service providers described in paragraph (1)(A)(ii); (iii) at least 6 grants to organizations described in subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act; (iv) at least 6 grants to organizations described in paragraph (1)(A)(iv); and

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEE.—The Secretary shall also ensure that the grantees under this section represent, among other factors—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of the Social Security Act; (ii) variations in languages needed and their frequency of use; (iii) urban and rural settings; (iv) at least two geographic regions, as defined by the Secretary; and

(v) at least two large metropolitan statistical areas with diverse populations.

(d) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for...
the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpreters, video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for competent translation services for Medicare beneficiaries in a grantee's service area if the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (i) shall be construed to exempt emergency rooms or similar entities that regularly provide health care services to Medicare beneficiaries from the demonstration program to provide medical emergency services to individuals with limited English proficiency.

(b) Reporting and grants.—(1) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to beneficiaries who are not limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services by the beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(c) Determination of payment for language services.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee's service area utilizing language services.

(A) data on the numbers of limited English proficient individuals who speak English less than fluently, available from the Bureau of the Census.

(B) data on the numbers of limited English proficient individuals who speak English less than fluently, as determined by the Secretary to yield accurate results.

(C) an analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to beneficiaries who are not limited English proficient Medicare beneficiaries not participating.
patients, providers, organizations that advocate on behalf of limited English proficient individuals, and other individuals or entities determined appropriate by the Secretary.

(b) Considerations.—In designating accreditation or training requirements under this section, the Secretary shall consider, as appropriate:

(1) standards for qualifications of health care interpreters who interpret infrequently encountered languages;
(2) standards for qualifications of health care interpreters who interpret in languages of lesser diffusion;
(3) standards for training of interpreters; and
(4) standards for continuing education of interpreters.

(1) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), or any other statute.

(2) APPROPRIATIONS.—There are appropriated to carry out this section, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $16,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) In General.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of enactment of this Act, a report on the impact of language access services on the health of limited English proficient populations.

(b) CONTENTS.—Such report shall include:

(1) recommendations on the development and implementation of policies and procedures by health care organizations and providers for limited English proficient patient populations;
(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and
(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 1224. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term "bilingual" with respect to an individual means a person who has sufficient degree of proficiency in two languages to enable effective communication in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term "competent interpreter services" means health care-related services to an LEP individual designed to enhance that individual's access to, understand, and benefit from health care or health care-related services.

(3) COMPETENT TRANSLATION SERVICES.—The term "competent translation services" means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and capture, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term "effective communication" means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms "interpreting" and "interpretation" mean the transmission of a spoken message from one language into another, faithfully, accurately, and comprehensively in the target language.

(6) HEALTH CARE SERVICES.—The term "health care services" means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term "health care-related services" means health or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term "language access" means the provision of language access services directly in a non-English language, interpretation, translation, and non-English signage.

(9) LANGUAGE SERVICES.—The term "language services" means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term "limited English proficient" or "LEP" with respect to an individual means an individual who has sufficient degree of proficiency in two languages to enable effective communication in both languages and can ensure effective communication can occur in both languages.

(11) MEDICARE BENEFICIARY.—The term "Medicare beneficiary" means an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title.

(12) MEDICARE COVERAGE FOR ESRD PATIENTS.—The term "Medicare program" means the programs under parts A through D of title XVIII of the Social Security Act.

(13) SERVICE PROVIDER.—The term "service provider" includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

Subtitle C—Miscellaneous Improvements

SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS PROCESS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–173), by striking "December 31, 2009" and inserting "December 31, 2011".

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVIDERS.

(a) Provision of Appropriate Coverage of Immunosuppressive Drugs Under the Medicare Program for Kidney Transplant Recipients.—

(1) Continued Entitlement to Immunosuppressive Drugs.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 1881 of such Act (42 U.S.C. 1395l(b)(2)) is amended by inserting "(except for coverage of immunosuppressive drugs under section 1861(e)(2)(J))" before ".

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1396m) is amended—

(i) by striking "Every individual who" and inserting "(a) In General.—Every individual who"; and

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

"(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs under this section 226a(b)(2), the following rules shall apply:

"(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

"(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program as defined in section 1144(c)(7) in order to receive such coverage.

"(C) The provision of such drugs shall be subject to—

(i) the deductible under section 1833(b); and

(ii) the coinsurance amount applicable for such drugs (as determined under this part).

"(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

"(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

(i) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226a(b)(2); and

(ii) distinguishing such individuals from individuals that are entitled to coverage of immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.

(b) Medicare Coverage for ESRD Patients.—Section 1881 of such Act is further amended—

(i) by striking a one-time election to be excluded from the phase-in (or the following new sentence: "With respect to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.

(ii) by striking "from the phase-in" and inserting "from phase-in or the remainder of the phase-in": and

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

"(b) IN GENERAL.—The case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2013, to be excluded from the phase-in (or the following new sentence: "With respect to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.

(c) Technical Amendment to Correct Duplication Subsection Designation.—Section (c) of section 226a of such Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) Extension of Secondary Payer Requirements for Kidney Transplant Patients.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: "With respect to immunosuppressive drugs furnished on or after the date of the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–173), by striking "December 31, 2009" and inserting "December 31, 2011".

Subsection (b) of section 1881(a) of such Act (42 U.S.C. 1395l(a)), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (a).
SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF LIMITED ENROLLMENT PENALTY FOR TRICARE BENEFICIARIES.

(a) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395y(a)) is amended by—

(B) by striking ‘‘(4) For purposes of this section, the term ‘voluntary advance care planning consultation’ means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, such consultation may include the following, as specified by the Secretary:’’ and (C) by adding at the end the following new subparagraph:

‘‘(FF) voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(hhhh)), which are performed more frequently than is covered under such section;’’; and

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

‘‘Voluntary Advance Care Planning Consultation

‘‘(hhh)(1) Subject to paragraphs (3) and (4), the term ‘voluntary advance care planning consultation’ means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

‘‘(A) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

‘‘(B) An explanation by the practitioner of technology infrastructure to collect the information and in using shared decision making aids for the conditions identified by the Secretary and in using shared decision making process using patient decision aids.

‘‘(3) In the case of an individual who enrols during the special enrolment period provided under paragraph (1), the coverage under subsection (b) of section 1857(j)(1) of title 10, United States Code, that begins on the first day of the month in which the individual enrols or, at the option of the individual, on the first day of the second month following the last month of the individual’s initial enrolment period.

‘‘(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrolment period described in paragraph (2).

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

(b) WAIVER OF INCREASE OF PREMIUM.—

(1) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395y(a)(4)(C)(i)(II)) is amended by inserting ‘‘subsection (i)(4) or (l) of section 1837’’ after ‘‘subsection (i)(3)’’.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums and payments for years beginning with 2011.

SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX YEAR IN CASE OF GAINS FROM SALE OF PRIMARY RESIDENCE.

(a) IN GENERAL.—The voluntary advance care planning consultation is described in subsection (hhh)(1) of the Social Security Act, as added by section 1907.

(b) SITES.—

(1) IN GENERAL.—The amendment made by this section shall apply to consultations made on or after the date of the enactment of this Act.

(2) A PPLICATION.—An eligible provider shall consult with the Secretary of Health and Human Services, acting through the Center for Medicare and Medicaid Innovation established under section 1072(5) of title 10, United States Code, and the Secretary of Defense, to identify health care professionals across the continuum of care.

(3) PREFERENCE.—In enrolling eligible providers, the Secretary shall give preference to Federal health care professionals who have experience in implementing, shared decision making process using patient decision aids.

(2) APPLICATION.—An eligible provider seeking to participate in the program shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(c) FOLLOW-UP COUNSELING VISIT.—

(1) IN GENERAL.—An eligible provider participating in the program shall routinely conduct follow-up counseling visit after the viewing of such a patient decision aid to answer any questions

SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT DECISION AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Center for Medicare and Medicaid Innovation established under section 1072(5) of title 10, United States Code, and the Secretary of Defense, to identify health care professionals, shall consult with the Secretary of Health and Human Services, acting through the Center for Medicare and Medicaid Innovation, to identify health care professionals across the continuum of care. The Secretary shall—

(1) require an individual to complete an advance directive, an order for life sustaining treatment, or another advance care planning document;

(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title; or

(3) encourage the promotion of suicide or assisted suicide.

(c) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ‘‘(2) an individual whose advance care planning consultation is described in subsection (hhh)(1)’’; and

(d) DURATION LIMITATION.—Section 1862(a)(2) of such Act (42 U.S.C. 1395y(a)(2)) is amended by—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ‘‘and’’ at the end of subparagraph (D) and (B) in subparagraph (O) by striking the semicolon at the end and inserting ‘‘; and’’; and

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

‘‘(P) in the case of voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(hhhh)), which are performed more frequently than is covered under such section;’’; and

(2) in paragraph (7), by striking ‘‘or (K)’’ and inserting ‘‘(K), or (P)’’.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to consultations furnished on or after January 1, 2011.

SEC. 1237. VOLUNTARY ADVANCE CARE PLAN-
the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their physical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services;

(B) of a single payment amount for such services that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eligible provider such as would be made under the applicable payment systems to that provider for similar covered services;

(C) costs of Aims.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider’s practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under title 42 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1381 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommendations for legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of health care services, and on improving the quality of life of such beneficiaries.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term "eligible provider" means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 361(a)(4) of the Social Security Act (42 U.S.C. 1386a(aa)(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of providing shared decision making and patient decision aids.

(2) PATIENT DECISION AID.—The term "patient decision aid" means a collabor-ative process between patient and clinician that engages the patient in decision making, provides patients with information about treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND CO-ORDINATED CARE

SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PROGRAM

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as added by section 1132(f), the following new sections:

"ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

"SEC. 1366E. (a) ESTABLISHMENT.—

(1) In General.—The Secretary shall conduct a pilot program (in this section referred to as the 'pilot program') to test different payment incentive models, including (to the extent practicable) payment incentive models described in subsection (c), designed to reduce the growth of expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (e)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

(A) promote accountability for a patient population and coordinate items and services under parts A and B and may include Part D, if the Secretary determines appropriate); (B) encourage investment in infrastructure and redesigned care processes for high quality and efficient care delivery; and

(C) reward physicians and other physician organizations for the provision of high quality and efficient health care services.

(2) SCOPE.—The Secretary shall set specific goals for the number of accountable care organizations, participating practitioners, and patients served in the initial tests under the pilot program to ensure that the pilot program is of sufficient size and scope to—

(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

(B) subject to subsection (g)(1), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a qualifying accountable care organization model to be successful in improving quality and reducing costs, the Secretary shall seek to implement such models on as large a geographic scale, economically feasible.

"(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOs).—

(1) QUALIFYING ACO DEFINED.—In this section:

(A) IN GENERAL.—The terms 'qualifying accountable care organization' and 'qualifying ACO' mean a physician organization or other physician organizational model (as defined in subparagraph (D)) that—

(i) is organized at least in part for the purpose of providing physicians' services; and

(ii) meets such criteria as the Secretary determines to be appropriate to participate in the program (including the criteria specified in paragraph (2)).

(B) INCLUSION OF OTHER PROVIDERS OF SERVICES AND SUPPLIES.—Nothing in this subsection shall be construed as preventing a qualifying ACO from including a hospital or any other provider of services or supplier furnishing items or services for which payments may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

(C) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise determine, the furnishing of services for which payment may be made as physicians' services under this title.

(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for a qualified accountable care organization.

(A) ELIGIBLE PROVIDER.—The term 'eligible provider' means the following:

(1) PERFORMANCE TARGET MODEL.—Under this program.

(B) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for a qualified accountable care organization:

(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the 'performance target model')—

(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if expenditures for items and services for applicable beneficiaries are at or below a target level of growth. Incentive payments may be made under this title that is affilated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

(B) PROGRAM.—(i) PAYMENT INCREASE.—The group includes a sufficient number of primary care physicians (regardless of specialty) for which the group is accountable for the costs of care (as determined by the Secretary).

(C) THE GROUP REPORTS ON QUALITY MEASURES AS FURNISHED TO THE SECRETARY AS APPLICABLE.

(D) OTHER PHYSICIAN ORGANIZATIONAL MODELS.—The term 'other physician organizational model', means with respect to a qualifying ACO for any model of organization other than an accountable care organization (as defined in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established for a per capita basis or adjusted for risk, as the Secretary determines to be appropriate.

CONGRESSIONAL RECORD — HOUSE
the Secretary. The Secretary may develop other payment models, operate at financial risk, or otherwise participate in alternative financing models under this section. The Secretary shall establish a process for developing annual targets that qualify for such beneficiaries if the pilot program under this paragraph shall not be included in the limit incentive payments to each qualifying ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(ii) LIMITATION.—The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this paragraph were not implemented.

(III) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries as determined by the Secretary.

(iv) REASURING.—Under this model the Secretary shall periodically rebase the expenditure amount described in clause (ii).

(IV) MEETING TARGET.—

(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meets or exceeds annual quality and performance targets for a year shall be entitled to incentive payments for each year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year exceed the performance target for such year, as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

(ii) LIMITATION.—The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary determines appropriate in order implementing whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

(1) PARTIAL CAPITATION MODEL.—

(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a ‘partial capitation model’) is a model in which a participating ACO would be held financially responsible for some, but not all, of the items and services covered under parts A and B (and may include part D, if the Secretary determines necessary in order implementing whether to make such payments) for its attributable Medicare beneficiaries. The Secretary may limit a partial capitation model to ACOs that are high-risk in terms of any of the applicable metrics and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—A qualifying ACO for items and services under this title for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in payments that exceed the Medicare payments for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(2) OTHER PAYMENT MODELS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency of care.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Paragraph (2) of this subparagraph shall apply to a payment model under subparagraph (A) if such subparagraph (B) applies to the payment model under paragraph (2).

(III) ANNUAL QUALITY TARGETS.—

(1) IN GENERAL.—The Secretary shall establish annual quality targets that qualifying ACOs must meet to receive incentive payments. Such targets may include part D, if the Secretary determines necessary in order implementing whether to make such payments.

(2) REBASING.—Under this model the Secretary may adjust the annual per capita amount that reflects changes in expenditures and quality of services under this title (including payments under title XVIII) with respect to any of the first 4 years of the pilot program and is consistently meeting quality standards or

(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

(3) TERMINATION.—The Secretary may terminate a model with a qualifying ACO under the pilot program if such ACO did not consistently meet quality standards during a multi-year period.

(4) EXPANSION TO ADDITIONAL ACOs.—

(A) IN GENERAL.—Subject to paragraph (B), the Secretary shall make public available a report on the use of ACO payment models under the pilot program. Such report shall describe the extent that such models on expenditures, access, and quality under this title.

(B) EXTENSION.—Subject to the report provided under paragraph (3), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate in order implementing whether to make such payments.

(5) ADMINISTRATION.—Chapter 35 of title 42, United States Code shall not apply to this section.

(g) EVALUATION; MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 180 days of the date of completion of such report.

(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the ‘Stark law’).

(3) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

(A) PREFERENCE.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement with such ACO under the pilot program as the Secretary determines appropriate in order implementing whether to make such payments.

(B) CERTIFICATION.—The Chief Actuary of the

(C) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter, the Secretary shall submit to Congress and make publicly available a report on the extent to which the Secretary determines appropriate in order implementing whether to make such payments.

(D) APPLICABLE BENEFICIARIES.—

(A) IN GENERAL.—In this section, the term ‘applicable beneficiaries’ means, with respect to a qualifying ACO, an individual who—

(i) is enrolled under part B and entitled to benefits under part A;

(ii) is not enrolled in a Medicare Advantage plan under part C of a Medicare program under section 1884;

(iii) meets such other criteria as the Secretary determines appropriate, which may include criteria based on the Secretary’s experience in implementing similar initiatives under section 1848, and may use alternative criteria than would otherwise be necessary in order implementing whether to make such payments.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Under this model the Secretary may adjust the amount that reflects changes in expenditures and quality of services under this title (including incentive payments described in subsection (g) and the Secretary’s experience in implementing similar initiatives under section 1848, and may use alternative criteria than would otherwise be necessary in order implementing whether to make such payments.

(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may make public any data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through qualifying ACOs.

(3) IMPLEMENTATION.—

(A) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

(B) WAIVER.—The Secretary may waive such provisions of this title (including section 1877 and title XI in the manner the Secretary determines necessary in order implementing the pilot program.

(4) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results for qualifying ACOs under the pilot program at least annually.

(A) IN GENERAL.—There shall be no administrative or judicial review under section 1889, section 1878, or otherwise of—

(i) the elements, parameters, scope, and duration of the pilot program as the Secretary determines necessary in order implementing whether to make such payments;

(ii) the selection of qualifying ACOs for the pilot program;

(iii) the establishment of targets, measure-ments, and evaluations with respect to whether savings have been achieved and the amount of savings;

(iv) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(v) decisions about the extension of the pilot program under subsection (b), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(B) DETERMINATIONS REGARDING EXTENSION.—

Subject to section 1869, section 1878, or otherwise of—

(i) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1889, section 1878, or otherwise of—

(ii) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(iii) decisions about the extension of the pilot program under subsection (b), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(6) ADMINISTRATION.—Chapter 35 of title 42, United States Code shall not apply to this section.

(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1889, section 1878, or otherwise of—

(i) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(ii) decisions about the extension of the pilot program under subsection (b), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(5) ADMINISTRATION.—Chapter 35 of title 42, United States Code shall not apply to this section.
and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

(2) SCOPE.—Subject to subsection (g), the Secretary shall set specific goals for the medical home pilot program, and the number of patients served, under the pilot program in the initial tests to ensure that the pilot program is of sufficient size and scope to:

(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

(B) sustain the practice (e), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a medical home model to be successful in improving quality and reducing costs, the Secretary shall implement such model on a large geographic scale as practical and economically.

(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (e).

(C) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

(A) Nothing in this section shall be construed as preventing a physician assistant from leading a patient centered medical home so long as:

(i) all the requirements of this section are met; and

(ii) the nurse practitioner is acting in a manner that is consistent with State law.

(B) Nothing shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as:

(i) all the requirements of this section are met; and

(ii) the physician assistant is acting in a manner that is consistent with State law.

(D) Definitions.—For purposes of this section:

(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'independent patient-centered medical home services' means services that—

(A) provide beneficiaries with direct and ongoing access to a primary care or principal care physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, provider of services, and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

(C) provide for all the patient’s health care needs or take responsibility for appropriately referring or otherwise managing other qualified physicians or providers for all stages of life;

(D) provide continuous access to care and communication with participating beneficiaries;

(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

(G) implement evidence-based guidelines and appropriate care planning and the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

(2) PRIMARY CARE.—The term ‘primary care’ means health care that is provided by a physician, nurse practitioner, or physician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

(3) PRINCIPAL CARE.—The term ‘principal care’ means integrated, accessible health care that is provided by a medical specialist or sub-specialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the specialist’s or sub-specialist’s expertise, and for whom the specialist or sub-specialist assumes care management.

(B) OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may create other third party arrangements, such as other than for payments for items and services described in section 2702(a)(1) of the Public Health Service Act.

(C) OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may create other third party arrangements, such as those described in section 2702(a)(1) of the Public Health Service Act.

(4) ANTIDISCRIMINATION LIMITATION.—The Secretary determines appropriate.

(A) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term ‘targeted high need beneficiary’ means a beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical home services based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.
(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

(i) The clinical work and practice expenses involved in providing the community-based medical services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this sub- section.

(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

(iii) Use appropriate risk-adjustment in determining the amount of the per bene-

ficiary per month payment under this para-

graph so that payments are made for higher risk bene-

ficiaries.

(iv) Encouraging participation of vari-

ety of practices.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent phys-

icians in large practices, particularly in underserved and rural areas, as well as federally qualified health centers, and rural health centers.

(2) COMMUNITY-BASED MEDICAL HOME DE-

FINED.—In this section, the term ‘community-

based medical home’ means a nonprofit community-based or State-based organiza-

tion or a State that is certified under para-

graph (2) as meeting the following require-

ments:

(i) The organization provides bene-

ficiaries with medical home services.

(ii) The organization provides medical home services under the supervision of the primary care or principal care physician, nurse practitioner, or physician assistant designated by the board or her community-based medical home provider.

(iii) The organization employs commu-

nity health workers, including nurses or other practitioners, in a large medical practice, particularly in underserved and rural areas, as well as federally qualified health centers, and rural health centers.

(iv) The organization meets other re-

quirements as the Secretary may specify.

(3) DURATION.—The pilot program for community-based medical homes under this subsection shall provide for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under para-

graph (6).

(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary shall give prefer-

ence to applications which seek to elimi-

nate duplicative and other medically unnec-

essary diagnostic tests, reduce inappropriate hospitalizations, and result in estimated spending under this title that is $5 billion less than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

(5) PAYMENTS.—

(A) Establishment of Methodology.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

(B) Payment Per Month Payments.—Under such payment methodology, the Secretary shall make two separate monthly payments for each beneficiary who enroll in a medical home that is under the CBMH model, the Secretary shall give pref-

erence to medical home services provided by the independent patient-centered medical home and shall establish a process for ensuring that medical homes meet such updated standards, as applicable.

(C) Prospective Payment.—The payments under subparagraph (B) shall be paid on a prospective basis.

(D) AMOUNT OF PAYMENT.—In determining the amount of such payment under para-

graph (B), the Secretary shall consider the following:

(i) The clinical work and practice expenses involved in providing the medical home services for chronically ill beneficiaries who rely, for primary care, on small physician groups or individual practitioners, that are making chronic ill-

nesses (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this sub-

section.

(ii) Use appropriate risk-adjustment in determining the amount of the per bene-

ficiary per month payment under this para-

graph.

(iii) In the case of the models described in subparagraphs (B) and (C) of paragraph (4), the Secretary may determine an appropriate payment amount.

(B) INITIAL IMPLEMENTATION FUNDING.—

The Secretary may make available initial implementation funding to a nonprofit community-based or State-based organization or a State that is participating in the pilot pro-

gram under this subsection. Such organiza-

tion shall provide the Secretary with a de-

tailed implementation plan that includes how such expansion will be funded and the Secretary shall select a territory of the United States as one of the locations in which to imple-

ment the pilot program under this sub-

section, unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that is $5 billion less than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

(5) ADMINISTRATIVE PROVISIONS.—

(1) NO DUPLICATION IN PAYMENTS FOR INDIVIDUALS IN MEDICAL HOMES.—During any month, the Secretary may not make pay-

ments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

(2) NO EFFECT ON PAYMENT FOR MEDICAL VISITS.—Payments made under this section are in addition to, and have no effect on the payment for medical visits made under this title.

(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this sec-

tion.
make payments to an independent or community-based medical home both under this section and section 1866E or 1866G, unless the pilot program under this section has been implemented or a permanent basis under subsection (e)(3).

“(5) WAIVER.—The Secretary may waive such provisions of this title and title XI in the manner the Secretary determines necessary in order to implement this section.

“(g) FUNDING.—

“(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

“(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

“(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

“(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5). Amounts available under this paragraph for a fiscal year shall be available until expended.

“(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

“(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

“(1) In addition to funds otherwise available for payment of medical home services under this section, the Secretary shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(5). Amounts available under this paragraph for a fiscal year shall be available until expended.

“(i) EFFECTIVE DATE.—The amendment made by this section shall be effective on or after January 1, 2011.

SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY CARE SERVICES.

(a) In General.—Section 1833(m) of the Social Security Act is amended by inserting after paragraph (2) the following new paragraph:

“(p) PRIMARY CARE PAYMENT INCENTIVES.—

“(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner under this section, the Secretary may—

“(A) mean evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under this title) for—

“(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1840(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 1841(a)(1)) of the Public Health Service Act) as a primary care health professional shortage area.

“(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term ‘primary care services’—

“(A) mean evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under this title) for—

“(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1840(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 1841(a)(1)) of the Public Health Service Act) as a primary care health professional shortage area.

“(2) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term ‘primary care practitioner’—

“(A) means a physician or other health care practitioner (including a nurse practitioner) who—

“(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

“(ii) has allowed charges for primary care services that account for at least 50 percent of the physician’s or practitioner’s total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

“(B) includes all practitioners who are under the supervision of a physician described in subparagraph (A) if furnished by a physician;

“(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term ‘primary care practitioner’—

“(A) means a physician or other health care practitioner (including a nurse practitioner) who—

“(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

“(ii) has allowed charges for primary care services that account for at least 50 percent of the physician’s or practitioner’s total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

“(B) includes all practitioners who are under the supervision of a physician described in subparagraph (A).

“(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

“(A) any determination or designation under this subsection;

“(B) the identification of services as primary care services under this subsection; and

“(C) the identification of a practitioner as a primary care practitioner under this subsection.

“(5) COORDINATION WITH OTHER PAYMENTS.—

“(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

“(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1841(g)(2)(B).

“(b) CONFORMING AMENDMENTS.—

“(1) SECTION 1305.—Section 1305(a) of such Act (42 U.S.C. 1395l(b)) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

“(4) The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

“(2) Section 1384(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting ‘‘, (p),’’ after ‘‘(m).’’

“(3) Section 1384(m)(4)(B)(iv) of such Act (42 U.S.C. 1395w–4(a)(1)(B)(iv)) is amended by inserting ‘‘primary care’’ before ‘‘health professional shortage area’’.

SEC. 1304. INCREASED DISBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) In General.—Section 133(a)(1)(K) of the Social Security Act (42 U.S.C. 1396a(a)(1)(K)) is amended by striking ‘‘(but in no event and all that follows through ‘‘performed by a physician’’).’’

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) MEDICARE COVERED PREVENTIVE SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by adding at the end the following new subsection:

“(M) Bone mass measurement (as defined in subsection (oo)).

“(N) Colorectal cancer screening tests (as defined in subsection (oo)).

“(O) Diabetes outpatient self-management training services (as defined in subsection (pp)).

“(P) Screening for glaucoma for certain individuals (as described in subsection (qq)).

“(Q) Medical nutrition therapy services for certain individuals (as described in subsection (qq)).

“(R) An initial preventive physical examination (as defined in subsection (ww)).

“(S) Cardiovascular screening blood tests (as defined in subsection (yy)).

“(T) Diabetes screening tests (as defined in subsection (yy)).

“(U) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (ww)).

“(V) Screening mammography (as defined in subsection (jj)).

“(W) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

“(X) Bone mass measurement (as defined in subsection (rr)).

“(Y) Kidney disease education services (as defined in subsection (ss)).

“(Z) Additional preventive services (as defined in subsection (dd)).

“(AA) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.

“(BB) PAYMENTS AND ELIMINATION OF COST-SHARING.—

“(1) IN GENERAL.—

“(A) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding after and below paragraph (b) the following:

“(AA) Medicare covered preventive services, in any case in which the payment rate otherwise provided under this part is different from the payment rate prescribed in this subsection.
is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.";

(2) Prevention and Early Detection.-Section 1343(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(i) in paragraph (2)(C), by amending clause (ii) to read as follows: ``(ii) No coinsurance.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied;''.

(3) Waiver of Coinsurance in Out-Patient Hospital Settings.—(A) Exclusion from OPP Fee Schedule.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(u)(1)(B)(iv)) is amended by striking ``screening mammography'' and inserting ``diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(i)(1))'';

(B) Conforming Amendment.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ``and'' after the semicolon at the end;

(ii) in subparagraph (G), by adding ``and'' at the end; and

(iii) by adding at the end the following new subparagraph: ``(ii) with respect to additional preventive services (as defined in section 1861(dd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (W);'';

(5) Waiver of Application of Deductible for All Preventive Services.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (i), by striking ``items and services described in section 1861(s)(10)(A)'' and inserting ``Medicare covered preventive services (as defined in section 1861(iii))'';

(B) by inserting ``and'' before ``(4);''; and

(C) by striking clauses (5) through (8);

(4) Application to Providers of Services.—(A) in paragraph (1)(A) of section 1833(c) of the Social Security Act (42 U.S.C. 1395l(c)(1)(A)) is amended by striking ``other than for Medicare covered preventive services and'' after ``for such items and services'';

(B) in paragraph (2)(E)(i), by striking and adding at the end the following new subparagraph: ``(EE) marriage and family therapist services (as defined in subsection (jjj));''.

(6) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2011.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANACRINAL TISSUE REMOVAL.

(a) In General.—Section 1833 of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 1303(b), is further amended—

(1) in subsection (a), in the sentence added by section 1305(b)(1)(A), by inserting ``(including services described in the last sentence of section 1833(b))'' after ``preventive services'';

(2) in subsection (b), by adding at the end the following new sentence: ``(ii) the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other material from a patient that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test;''

(b) Effective Date.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.
mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law. The State shall promulgate a mechanism provided by the State law of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

(2) The term ‘mental health counselor’ means an individual who—

(A) possesses a master’s or doctor’s degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

(B) after obtaining such a degree has performed at least two years of supervised mental health counselor practice; and

(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

(3) PROVISION FOR PAYMENT UNDER PART B—Section 182a(a)(2)(B) of the Social Security Act (42 U.S.C. 1395a(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking ‘‘and’’ at the end of clause (iv);

(B) by adding ‘‘and’’ at the end of clause (v); and

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

‘‘(vi) mental health counselor services;’’.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is further amended—

(i) by striking ‘‘and’’ before ‘‘(X)’’; and

(ii) by inserting before the semicolon at the end the following: ‘‘, and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)’’;

(B) EFFECTIVE DATE.—The amendments made under this paragraph shall be effective beginning on October 1, 2010.

(5) EXCLUSION OF MENTAL HEALTH COUNSELORS FROM SKILLED NURSING FACILITY PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395v(e)(2)(A)(ii)), as amended by section 1307(i) and subsection (a), is amended by inserting ‘‘(1) mental health counselor services (as defined in section 1861( kk)(k)(ii)),’’ after ‘‘(1) marriage and family therapist services (as defined in subsection(jj)(i))’’, and

(6) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERA LLY QUALIFIED HEALTH CENTERS.—Section 1395w–3a(f) is amended—

(a) IN GENERAL.—Section 1847A(f) of such Act (42 U.S.C. 1395w–3a(f)) is amended—

(1) by inserting ‘‘and’’ after ‘‘(A)’’ and before ‘‘(B)’’;

(2) by striking ‘‘For’’ and inserting ‘‘(1) IN GENERAL.—’’;

(3) by striking ‘‘For’’ and inserting ‘‘(2) TREATMENT OF CERTAIN MANUFACTURERS’’; and

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF PROFESSIONAL FREESCHED ULE MEDICAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ‘‘December 31, 2009’’ and inserting ‘‘December 31, 2010’’.

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395h(s)) is amended to read as follows:

‘‘(10) federally approved and recommended vaccines (as defined in subsection (ii)); and their respective administration;’’.

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

‘‘Federally Approved and Recommended Vaccines’’

‘‘(iii) The term ‘federally approved and recommended vaccine’ means a vaccine that—

(1) is licensed under section 351 of the Public Health Service Act or approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

(2) is recommended by the Director of the Centers for Disease Control and Prevention.’’

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking ‘‘1986(s)(10)(A)’’ and inserting ‘‘1986(s)(10)’’ each place it appears.

(2) Section 1842A(c)(1)(A)(iv) of such Act (42 U.S.C. 1395w–3a(c)(1)(A)(iv)) is amended—

(A) by striking ‘‘paragraph (A) or (B) of’’; and

(B) by inserting before the period the following:

‘‘and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011’’;

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting ‘‘including a vaccine furnished on or after January 1, 2011, and influenza vaccines’’;

(B) by the following new paragraph:

‘‘(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to the payment and furnishing of information pursuant to section 1927(b)(3)(A)(iii) or subsection (f)(2) for purposes of implementation of this section.’’

(d) CONFORMING AMENDMENTS.—Section 1302 of such Act (42 U.S.C. 1395w–3a(f)) is amended—

(1) by this section (other than by subsection (c)) and

(2) by this section (other than by subsection (c)).

SEC. 1311. EXPANSION OF MEDI CARE-COVERED PREVENTIVE SERVICES AT FEDERA LLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1395w–3a(f) of the Social Security Act (42 U.S.C. 1395w–3a(f)) is amended to read as follows:

‘‘(f) INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1860F, the following new section:

‘‘1311. INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—(1) IN GENERAL.—The Secretary shall conduct a demonstration program in this section referred to as the ‘demonstration program’ to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce excess expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

(b) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

(1) reducing hospital preventable hospitalizations;

(2) preventing hospital readmissions;

(3) reducing emergency room visits;

(4) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;

(5) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

(6) reducing the cost of health care services covered under this title; and

(7) achieving beneficiary and family caregiver satisfaction.

(b) INDEPENDENCE AT HOME MEDICAL PRACTICE—.”
"(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:
"(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that is organized in accordance with this section, and is operated by one or more primary care practitioners, and is subject to the Secretary’s review and oversight.
"(B) PHYSICIAN.—The term 'physician' includes a doctor of medicine, doctor of osteopathic medicine, or a doctor of dental medicine.
"(C) PHYSICIAN ASSISTANT.—The term 'physician assistant' includes a person who is licensed to practice as a physician assistant in the State in which the entity is located.
"(D) NURSE.—The term 'nurse' includes a registered nurse, a licensed practical nurse, and a licensed vocational nurse.
"(E) APPLICABLE BENEFICIARIES.—The term 'applicable beneficiaries' means beneficiaries who are enrolled in the demonstration program.

"(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed as preventing a nurse practitioner or physician assistant from participating in the demonstration program, as the case may be, in a manner consistent with State law and regulation.

"(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—In this subsection, the term 'provider' includes a primary care practitioner who is acting in a capacity other than as a member of a medical practice.

"(4) QUALITY AND PERFORMANCE STANDARDS.—(A) IN GENERAL.—An independence at home medical practice participating in the demonstration program shall report on quality measures in accordance with such standards and guidelines as the Secretary establishes.

"(5) NUMBER OF PRACTICES.—The Secretary shall establish annual spending level targets for groups of practices or single practices, based on the expected savings to Medicare as a result of the demonstration program.

"(6) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall establish a procedure for patients to elect to participate in the demonstration program.

"(7) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(8) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(9) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(10) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(11) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(A) IN GENERAL.—An independence at home medical practice shall report on quality measures in accordance with such standards and guidelines as the Secretary establishes.

"(B) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(C) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(D) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(E) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(F) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(G) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(H) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(I) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(J) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(K) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(L) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(M) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(N) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(O) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(P) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(Q) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(R) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(S) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(T) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(U) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(V) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(W) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(X) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(Y) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(Z) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(AA) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(BB) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(CC) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(DD) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(EE) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(FF) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(GG) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(HH) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(II) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(JJ) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(KK) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(LL) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(MM) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(NN) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(OO) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(PP) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(QQ) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(RR) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(SS) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(TT) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(UU) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(VV) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(WW) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(XX) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(YY) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(ZZ) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(AAA) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(BBB) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(CCC) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.

"(DDD) INDEPENDENCE AT HOME MEDICAL PRACTICE.—The term 'independence at home medical practice' means an entity that is organized in accordance with this section, and is subject to the Secretary’s review and oversight.

"(EEE) APPOINTMENT OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—The Secretary shall establish a procedure for the appointment of nurse practitioners and physician assistants to the independence at home medical practice.

"(FFF) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall establish quality and performance standards for the demonstration program.

"(GGG) FINANCIAL ARRANGEMENTS.—The Secretary shall establish financial arrangements for the demonstration program.

"(HHH) MONITORING AND EVALUATION.—The Secretary shall establish a monitoring and evaluation plan for the demonstration program.
‘(f) EVALUATION AND MONITORING.—
‘(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

‘(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures under this title, including past practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

‘(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services under this title, and shared savings under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplemental Medical Insurance Trust Fund under section 1841 $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

‘(1) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under this demonstration program unless such entity guarantees that for individuals eligible to be enrolled in such program, the entity will not deny, limit, or condition the coverage or provision of benefits to which the individual would have otherwise been entitled to on the basis of health status if not included in this program.

‘(j) TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice if such practice does not manage incentivized payments under subsection (c)(2) or consistently fails to meet quality standards.”.

SEC. 1313. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDI-CARE DIABETES OUTPATIENT SELF-CARE MANAGEMENT SERVICES.

(a) In general.—Section 1861(q)(q) of the Social Security Act (42 U.S.C. 1395x(q)(q)) is amended by adding at the end the following new part:

‘(i) the National Certification Board for Diabetes Educators, or

‘(ii) a certifying body for diabetes educators, which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary, if the Secretary determines such Board or body, respectively, meets the requirement of subparagraph (B).

(b) The National Certification Board for Diabetes Educators or a certifying body for diabetes educators meets the requirement of this subparagraph, with respect to the certifying body or Board, respectively, is incorporated and registered to do business in the United States and requires as a condition of such certification each individual who—

‘(i) the individual has a qualifying credential in a specified health care profession.

‘(ii) The individual has professional practice experience in diabetes self-management training that includes a minimum number of hours and years of experience in such training.

‘(iii) The individual has successfully completed a national certification examination offered by such entity.

‘(iv) The individual periodically renews certification status following initial certification.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to diabetes outpatient self-management training services furnished on or after the first day of the first calendar year that is at least 6 months after the date of the enactment of this Act.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding at the end the following new title:

‘PART D—COMPARATIVE EFFECTIVENESS RESEARCH

‘COMPARATIVE EFFECTIVENESS RESEARCH

‘SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

‘(1) IN GENERAL.—There is established in the National Institutes of Health a Center for Comparative Effectiveness Research (in this section referred to as the ‘Center’). The Center shall be the independent Comparative Effectiveness Research entity for the purposes of the Medicare and Medicaid programs, and shall be responsible for conducting and supporting research conducted or supported under title 103 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

‘(2) DUTIES.—The Center shall—

‘(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services, and systems, including pharmacueticals, medical devices, medical and surgical procedures, and other medical interventions;

‘(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

‘(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

‘(D) submit to the Comparative Effectiveness Research Coordinating Office, the Secretary, and Congress appropriate reports described in subsection (d)(2);

‘(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for highly credible research;

‘(F) encourage, as appropriate, the development and use of clinical pathways, and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance data, and other forms of electronic health data; and

‘(G) appoint clinical perspective advisory panels for research priorities under this section that shall consist of independent experts and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

‘(a) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out its function. Upon request of the Center, the head of such department or agency shall furnish that information to the Center on an agreed upon schedule.

‘(b) DATA COLLECTION.—In order to carry out its functions, the Center shall—

‘(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

‘(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

‘(iii) adopt procedures allowing any interested party to submit information for the use by the Center in making reports and recommendations.

In carrying out clause (ii), the Center may award grants or contracts (or provide for intergovernmental transfers, as applicable) to private entities and governmental agencies with experience in conducting comparative effectiveness research, such as the National Institutes of Health and other relevant Federal health agencies.

‘(C) ACCESS OF GOVERNMENT.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

‘(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

‘(b) COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

‘(1) IN GENERAL.—There is established an independent Comparative Effectiveness Research Commission (in this section referred to as the ‘Commission’) to advise the Secretary and evaluate the activities carried out by the Center under subsection (a) to ensure that the priorities for research described in subsection (a) result in highly credible research and information resulting from such research.

‘(2) DUTIES.—The Commission shall—

‘(A) recommend to the Commission national priorities for research described in subsection (a) which shall take into account—

‘(i) disease incidence, prevalence, and burden in the United States;

‘(ii) evidence gaps in terms of clinical outcomes;
be submitted to the Office of Management and Budget, and to the President regarding research conducted by the Center under subsection (a)(2)(G) regarding a ‘par-ticular matter’ (as that term is used in section 208 of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D) for service on the Comptroller General’s (the Comptroller General) review of the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written deter-mination as referred to in section 208(b)(1) of title 18, United States Code, a written cer-tification as referred to in section 208(b)(3)
Government employee or special Government employee shall disclose to the Comptroller General or Secretary, respectively, financial interests in accordance with requiring a submission 28(b) of title 18, United States Code, or other interests as deemed relevant by the Secretary.

(iii) Prohibitions on participation.—Except as provided in clause (ii), the clinical perspective advisory panel described in subsection (a)(2)(G) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if such member has a financial interest in research conducted, supported, or synthesized in a meeting of the Commission or the clinical perspective advisory panel.

(iv) Limitation on waivers and other exceptions.—In determining allowable exceptions for the Commission, the Comptroller General or Secretary, respectively, may grant a waiver of the prohibition in clause (ii) to permit a member described in such clause to participate with respect to a particular matter considered in a meeting of the Commission.

(v) Determination of allowable exceptions for the Commission.—The number of waivers granted to members of the Commission cannot exceed one-half of the total number of members for the Commission.

(vi) Prohibition on voting status on clinical perspective advisory panels.—No voting member of any clinical perspective advisory panel shall be in receipt of a waiver. No more than two nonvoting members of any clinical perspective advisory panel shall receive a waiver.

(vii) Fiduciary interest defined.—For purposes of this paragraph, the term ‘fiduciary interest’ means a financial interest under section 208(a) of title 18, United States Code.

(viii) Application of FACA.—The Federal Advisory Committee Act (other than section 14 of such Act) shall apply to the Commission to the extent that the provisions of such Act do not conflict with the requirements of this subsection.

(ix) Research requirements.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

(A) The establishment of a research agenda by the Center shall be informed by the national priorities for research recommended under subsection (b)(2)(A).

(B) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

(C) Methods of conducting such research shall be scientifically based.

(D) Use of applicable law, all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent and provide public comment on the methods and findings of such research.

(E) Consistent with applicable law, the process and methods for conducting such research shall be publicly documented and available to all stakeholders.

(F) Throughout the process of such research, the Center shall provide opportunities for external review and public comment on the methods and findings of such research.

(G) Such research shall consider advice given to the Secretary of the Commission or the clinical perspective advisory panel described in subsection (a)(2)(G) essential expertise, the Center may be needed, as appropriate;

(h) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

(ix) Public access to comparative effectiveness information.—Research shall—

(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items, services, and technologies, with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), individuals with disabilities, and individuals with different comorbidities and genetic and molecular subtypes; and—

(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

(x) Dissemination.—The Center shall provide for the dissemination of comparative effectiveness information to appropriate users of health information technology focused on clinical decision support, relevant experts or organizations, such as public and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions; and

(B) discuss findings and other considerations specific to certain subpopulations, such as companies, and other entities as appropriate.

(C) Include considerations such as limitations of research and what further research may be needed, as appropriate.

(D) Do not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of the data under this section.

(E) The National Library of Medicine shall be the repository of the data and findings of such research in clinical decision support technologies. In disseminating such findings into clinical practices and promote the ease of use of such incorporation.

Funding for Comparative Effectiveness Research—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Fund (referred to in this section as the ‘CERTF’) under section 5911 of the Internal Revenue Code of 1986 shall be available in accordance with such section, without the need for further appropriations and without fiscal year limitation, to carry out this section.

Construction—Nothing in this section shall be construed—

(A) to permit the Center or Commission to make determinations of any kind or other policies for any public or private payer; or

(B) to require the use of data and findings for any public or private payer; or

(C) to preclude the consideration of relevant data and findings.
“(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI by such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.”

(2) [Provision]

(3) Protecting the physician-patient relationship.—Nothing in this section shall be construed to authorize the Secretary to require any Federal officer or employee to exercise any supervision or control over the practice of medicine.

(1) Consultation with relevant expert organizations.—

(1) Consultation prior to initiation of research.—Prior to recommending priorities or initiating research described in this section, the Commission or the Center shall consult with the relevant expert organizations responsible for standards and protocols of clinical excellence. Such consultation shall be consistent with processes established under subsection (c)(2).

(2) Consultation in dissemination of research.—Any dissemination of research findings made by the Commission or the Center shall be consistent with processes established under subsection (e) and shall—

(1) be based upon evidence-based medicine; and

(2) take into consideration standards and protocols of clinical excellence developed by relevant expert organizations.

(3) Definitions.—For purposes of this subsection:

(A) Relevant expert organizations.—The term ‘relevant expert organization’ means an organization with expertise in the rigorous application of evidence-based scientific methods for the design of clinical studies, the interpretation of clinical data, and the development of national clinical practice guidelines, including a voluntary health organization, clinical specialty, or other professional organization that represents physicians based on the field of medicine in which each such physician practices or is board certified.

(B) Standards and protocols of clinical excellence.—The term ‘standards and protocols of clinical excellence’ means clinical or organizational practices that constitute a set of directions or principles that is based on evidence and is designed to assist a health care practitioner with decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances.

(4) Research may not be used to deny dialysis care.—Nothing in this section shall be construed to make more stringent or otherwise change the standards or requirements for the coverage or reimbursement of items and services under this Act.

(b) Comparative effectiveness research trust fund; financing for the trust fund.—For the provision establishing a Comparative Effectiveness Research Trust Fund and financing such Trust Fund, see section 1802.

Subpart B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES, NURSING FACILITIES, AND OTHER LONG-TERM CARE FACILITIES

SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION

(a) In general.—Section 1121 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subpart:

(c) Required disclosure of ownership and additional disclosable parties information.

(1) Disclosure.—A facility (as defined in paragraph (6)(B)) shall have the information described in paragraph (3) available—

(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 1114(b) of the Affordable Care Act for, submission to the Secretary, the Inspector General of the Department of Health and Human Services (in the case in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

(3) Public availability of information.—During the period described in paragraph (1)(A), a facility shall—

(A) make the information described in paragraph (2) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

(4) Definitions.—In this subsection:

(A) In general.—The following information is described in this paragraph:

(i) The information described in subsections (a) and (b), subject to subparagraph (C).

(ii) The identity of and information on—

(I) each governing body of the facility, including the name, title, and period of service of each such member;

(II) each person or entity who is an officer, director, trustee, or manager of the facility, including the name, title, and date of start of service of such person or entity; and

(iii) each person who is an additional disclosable party of the facility.

(B) Organizational structure.—The term ‘organizational structure’ means an organization with expertise in the interpretation of clinical data, and the relationship of each person and entity described in subclauses (I) and (II) of clause (ii) to the facility and to another.

(C) Special rule.—In applying subparagraph (A)(i) with respect to subsections (a) and (b), ‘ownership or control interest’ shall include direct or indirect interests, including such interests in intermediate entities; and

(ii) subsections (a) and (b) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any part of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entity.

(4) Reporting.—

(A) In general.—Not later than the date that is 2 years after the date of the enactment of this title, the Secretary shall promulgate regulations requiring a facility to report the information described in paragraph (3)(B) to the Secretary in a standardized format and as may be necessary to carry out this subsection. Such regulations shall specify the frequency of reporting and shall be consistent with processes established under this subsection.

(ii) the reporting of such information on or after the first day of the first calendar quarter beginning after the date that is 90 days after the date on which such final regulations are published in the Federal Register; and

(iii) the certification, as a condition of participation under the program under title XVIII or XIX, that such information is accurate and current.

(B) Guidance.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

(C) Rules and regulations.—In addition to any existing reporting requirements under this section, nothing in this section shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

(D) Definitions.—In this subsection:

(i) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who, through ownership interest, partnership interest, contract (whether direct or indirect), or in any manner, controls, exercises control over, or exercises any supervision or control over the practice of medicine.

(ii) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who, through ownership interest, partnership interest, contract (whether direct or indirect), or in any manner, controls, exercises control over, or exercises any supervision or control over the practice of medicine.

(iii) Skilled nursing facility.—The term ‘skilled nursing facility’ means—

(A) a skilled nursing facility (as defined in section 1819(a)); or

(B) a nursing facility (as defined in section 1819(a)).

(C) MANAGING EMPLOYEE.—The term ‘managing employee’ means—

(i) a corporation, the officers, directors, managers, or employees of the facility, including the name, title, and percentage each member and manager has of the total property or assets of the entity; and

(ii) an owner or officer or manager of an additional disclosable party of the facility.

(D) ORGANIZATIONAL STRUCTURE.—The term ‘organizational structure’ means, in these cases:

(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percent of the ownership interest in the limited liability company);
VerDate Nov 24 2008 05:01 Nov 08, 2009 Jkt 089060 PO 00000 Frm 00116 Fmt 0636 Sfmt 0634 E:\CR\FM\A07NO7.020 H07NOPT1wwoods2 on DSK1DXX6B1PROD with HOUSE

deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation, which shall include recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

(iii) COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term ‘compliance and ethics program’ means, with respect to a skilled nursing facility, a program of the operating organization that—

(1) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(2) includes at least the required components specified in clause (iv).

(iv) REQUIRED COMPONENTS OF PROGRAM.—

The required components of a compliance and ethics program of an organization are the following:

(1) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(2) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance and procedures and have sufficient resources and authority to assure such compliance.

(3) The organization must have used due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(4) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner.

(5) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(6) The organization must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failings of the program.

(7) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense, to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

(VIII) The organization must periodically undertake reassessment of its compliance and ethics program to reflect changes within the organization and its facilities.

(V) COORDINATION.—The provisions of this subparagraph with respect to a skilled nursing facility in lieu of section 1874(d)."
(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through its due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(V) The organization must have taken reasonable steps to achieve compliance with its standards by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act.

(VII) After an offense has been detected, the organization must have taken all reasonable steps to appropriately report and to prevent similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

(VIII) The organization must periodically update its QAPI program to identify changes necessary to reflect changes within the organization and its facilities.

(II) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(7).

(II) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(I) Skilled Nursing Facilities.—Section 1919(b)(1)(B) of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by striking “ASSURANCE” and inserting “ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM”;

(B) by designating the matter beginning with “A nursing facility” as a clause (i) with the heading “IN GENERAL.—” and the appropriate indentation; and

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

“(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the ‘QAPI program’) for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (I).

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.

(III) PROPOSAL TO REVISE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—

Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) in subsection (b)(1)(B), in the matter following “(vii) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(7)”, by striking “(I) Skilled Nursing Facilities.—” and inserting “(I) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities (including those listed in 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (I) of such sections.

(2) GAO STUDY ON NURSING FACILITY UNDERCAPITALIZATION.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities (including those listed in 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (I) of such sections.

(B) The effects of such undercapitalization on the quality of nursing and food costs, at such facilities.

(C) Options to address such undercapitalization, such as requirements relating to surcharge bonds, liability insurance, or minimum capitalization.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).
(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

(i) that were committed inside the facility;

(ii) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury; and

(viii) The number of civil monetary penalties assessed with respect to the facility, employees, contractors, and other agents.

(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (iv) identifying information on complainants or residents.

(B) Deadline for provision of information.

(i) In general.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) Exception.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

(2) Review and modification of website.

(A) In general.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

(2) Timeliness of submission of survey and certification information.

(A) In general.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) Submission of survey and certification information to the Secretary.—In order to improve the timeliness of information made available to the public under paragraph (A) and provided on the Nursing Home Compare Medicare website under subsection (b) of such section, the Secretary shall submit information respecting any survey or certification recommendation made respecting a skilled nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.".

(B) Effective date.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) Special focus facility program.

Section 1819(b)(8) of such Act is amended by adding at the end the following new paragraph:

"(b) Special focus facility program.—

"(A) In general.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as high risk through a facility’s history of, or that substantially failed to meet applicable requirements of this Act.

"(B) Periodic surveys.—Under such program the Secretary shall conduct surveys of each facility in the program not less than 4 times a calendar year.

(4) Certification information to the Secretary.—In general.—Section 1919(a)(7) of the Social Security Act (42 U.S.C. 1395i–3(a)(7)) is amended by adding at the end the following new subparagraph:

"(A) In general.—Section 1919(c)(5)(B) of the Social Security Act (42 U.S.C. 1395i–2(b)(5)(B)), as added by section 501 of the Patient Protection and Affordable Care Act, is amended by adding at the end the following new subparagraph:

"(i) that were committed inside of the facility; and

(ii) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury.

(viii) the number of civil monetary penalties assessed with respect to the facility, employees, contractors, and other agents.

(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (vii) identifying information on complainants or residents.

(B) Deadline for provision of information.

(i) In general.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) Exception.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

(2) Review and modification of website.

(A) In general.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, and comprehensiveness of information provided for comparison of nursing homes on the official internet website of the Medicare benefits and coverage program (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searches on such website (or an successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) Not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

(2) Timeliness of submission of survey and certification information.

(A) In general.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) Submission of survey and certification information to the Secretary.—In order to improve the timeliness of information made available to the public under paragraph (A) and provided on the Nursing Home Compare Medicare website under subsection (b) of such section, the Secretary shall submit information respecting any survey or certification recommendation made respecting a skilled nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly."

(B) Effective date.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.
Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification recommendation made respecting a nursing facility (including any enforcement action taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which such information is made available to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Internet website of the State, that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information in the current certification status. (2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(a) by striking “and” at the end of subsection (B); and

(b) by striking the semicolon at the end of subparagraph (C) and inserting “; and”;

and (c) by striking at the end the following new subparagraph:

“(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility’s plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of care or other issues relating to the quality of care provided by individual facilities.”

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term “nursing facility” means the Secretary of Health and Human Services.

(B) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1281 of the Social Security Act (42 U.S.C. 1395yy).

(C) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 1413. STANDARDIZED COMPLAINT FORM.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new paragraph:

“(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new paragraph:

“(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility in a State—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.”

(3) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INVESTIGATION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility’s plan of correction or other response to such Form 2567 State inspection reports (or a successor form) of the Secretary that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information in the current certification status.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(a) by striking “and” at the end of subparagraph (B); and

(b) by striking the semicolon at the end of subparagraph (C) and inserting “; and”;

and (c) by striking at the end the following new subparagraph:

“(D) that the State establish a complaint resolution process in accordance with the provisions of section 1919(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(F) REPORTING OF DIRECT CARE EXPENDITURES.—

(i) IN GENERAL.—For cost reports submitted under this title for cost reporting periods ending on dates that are no more than two years after the redesign of the report specified in subparagraph (2), skilled nursing facilities shall—

(A) separately report expenditures for wages and benefits for direct care staff (breaking out at a minimum) registered nurses, licensed professional nurses, certified nurses’ aides, licensed practical nurses, nurse assistants, and other medical and therapy staff; and

(B) take into account agency and con-

tract staff in a manner to be determined by the Administrator.

(ii) MODIFICATION OF FORM.—The Secre-

tary, in consultation with the Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other experts, shall by regulation require each skilled nursing facility to meet the requirement of paragraph (1) not later than 2 years after the date of the enactment of this subsection.

(iii) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Beginning with cost reports submitted under paragraph (1), the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other experts, shall develop a standardized complaint form for use by a resident (or a person acting on the resident’s behalf) in filing a complaint with a State, whether the resident, legal representative, or other State nursing facility ombudsman program to respect the quality of care provided by such a skilled nursing facility.

(2) STATE REQUIREMENTS.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

“(D) COMPLAINT PROCESSES AND WHISTLE-

BLOWER PROTECTION.—(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (c)(9) available upon request to—

(i) a resident of a skilled nursing facility;

(ii) any person acting on the resident’s behalf; and

(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or other responsible party reports a complaint or information about the quality of care or other issues relating to the skilled nursing facility, that the legal representative or other responsible party is not retaliated against if the resident, legal representative, or other responsible party is not denied access to such resident or otherwise retaliated against if such representative has filed a complaint, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or other issues relating to the quality of care or services provided at the facility, whether the resident, legal representative, or other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint, Such complaint resolu-

tion process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely se-

verity of a complaint and for the investiga-

tion to the complainant that a complaint

has been received; and

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to protect the identity of the complainant will be kept confidential.

SEC. 1415. STANDARDIZED COMPLAINT FORM.

(a) SKILLED NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Sec-

tary, in consultation with the Payment Advisory Commission, the Inspector General of the Department of Health and Human Services and all other State nursing facility ombudsman programs, shall develop a standardized complaint form for use by a resident (or a person acting on the resident’s behalf) in filing a complaint with a State, whether the resident, legal representative, or any other State nursing facility ombudsman program to respect the quality of care provided by such a skilled nursing facility.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(a) by striking “and” at the end of subparagraph (B); and

(b) by striking the semicolon at the end of subparagraph (C) and inserting “; and”;

and (c) by striking at the end the following new subparagraph:

“(D) that the State require all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility’s plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of care or other issues relating to the skilled nursing facility, that the legal representative or other responsible party is not denied access to such resident or otherwise retaliated against if such representative has filed a complaint, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or other issues relating to the quality of care or services provided at the facility, whether the resident, legal representative, or other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint, Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely se-

verity of a complaint and for the investiga-

tion to the complainant that a complaint

has been received; and

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to protect the identity of the complainant will be kept confidential.

(3) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.
"3(1) Whistleblower Protection.—

(i) Prohibition Against Retaliation.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for employment, diminished by contract or other agreement, in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

(ii) Retaliatory Reporting.—A skilled nursing facility may not file a complaint or a report against a person who worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person’s request) complained in good faith, as described in clause (i).

(iii) Relief.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain all appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

(iv) Rights Not Waivable.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed as preventing the Secretary from reprimanding a skilled nursing facility (or a person acting at the facility’s behalf) for failing to comply with this paragraph.

(v) Requirement to Post Notice of Employee Rights.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility on behalf of a resident of the facility, that the legal representative of a resident of a nursing facility, or other responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a nursing facility or other responsible party has not been allowed access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about the quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(b) Nursing Facilities.—

(1) Development by the Secretary.—

(i) Section 1916(f)(9) (including submitting a complaint in a manner specified by the Secretary) shall be construed as preventing the Secretary from requiring the filing of a complaint if the individual reasonably believes—

(ii) the information reported in the complaint is true; and

(iii) retaliatory reporting.

(2) State Requirements.—

(1) Section 1916(e) of the Social Security Act (42 U.S.C. 1395i-3(e)) is amended by adding at the end the following new paragraph:

(iii) the information reported or disclosed in the complaint is true; and

(ii) the violation of this title has occurred in good faith.

(2) Section 1416(b)(9) of the Social Security Act (42 U.S.C. 1396i-3(b)(9)) is amended by adding at the end the following new paragraph:

(3) the information reported or disclosed in the complaint is true; and

(i) the violation of this title has occurred in good faith.

(3) (iv) Rights Not Waivable.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this subparagraph shall be construed as preventing the Secretary from reprimanding a skilled nursing facility (or a person acting at the facility’s behalf) for failing to comply with this paragraph.

(4) Requirement to Post Notice of Employee Rights.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility on behalf of a resident of the facility, that the legal representative of a resident of a nursing facility, or other responsible party has complained, in good faith, about the quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(5) Whistleblower Protection.—

(i) Prohibition Against Retaliation.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for employment, diminished by contract or other agreement, in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(6) Rule of Construction.—Nothing in this paragraph shall be construed as preventing the Secretary from reprimanding a skilled nursing facility (or a person acting at the facility’s behalf) for failing to comply with this paragraph.
staff shall be kept separate from information on employee staffing.

(b) NURSING FACILITIES.—Section 191(b)(8) of the Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by adding at the end the following new subparagraph:

"(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—On and after the first day of the calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such program, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

"(i) that the Secretary has not entered into an agreement under subsection (c)(1) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were not otherwise required to be conducted by such long-term care facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under subsection (c)(1); and

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were not otherwise required to be conducted by such long-term care facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain a State and national criminal history record check performed under the nationwide program; and

(B) have procedures in place to—

(i) monitor compliance by long-term care facility or provider of the procedures and requirements of the nationwide program;

(ii) as appropriate, provide for a provi-

sion for appeals for direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(iii) as appropriate, provide for a provi-

sion for appeals for direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(iv) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the development of the results of the selec-

tion of the most appropriate criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has a prior conviction for a rele-

vant crime;

(III) immediately reporting to the long-

term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a con-

viction for a relevant crime that is subject to reporting under section 1128E of the So-

cial Security Act (42 U.S.C. 1320a–7e), report-

ing the existence of such conviction to the designated agency established under this section;

(v) determine which individuals are direct

patient access employees (as defined in para-

graph (6)(B)) for purposes of the nationwide program;

(vi) as appropriate, specify offenses, in-

cluding convictions for violent crimes, for purposes of the nationwide program; and

(vii) describe and test methods that re-

duce duplicative fingerprinting, including

providing for the development of "rap back" capability for the State such that, if a direct patient access employee of a long-term care facility or pro-

vider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, the designated agency shall match the prints on file with the State law enforcement department, the department will imme-

diately inform the State and the State will immediately inform the long-term care facili-

ty or provider which employs the direct pa-

tient access employee of such conviction.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compli-

ance with the requirements of the nation-

wide program;

(B) have procedures in place to—

(i) conduct screening and criminal or other background checks consistent with the requirements of the nationwide program in accordance with the require-

ments of this section;

(ii) monitor compliance by long-term care facili-

ties and providers with the procedures and require-

ments of the nationwide program;

(iii) as appropriate, provide for a provi-

sion for appeals for direct patient access em-

ployees, not to exceed 60 days, pending com-

pletion of the required criminal history back-

ground checks performed under such pro-

gram; and

(iv) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the development of the results of the selec-

tion of the most appropriate criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has a prior conviction for a rele-

vant crime;

(III) immediately reporting to the long-

term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a con-

viction for a relevant crime that is subject to reporting under section 1128E of the So-

cial Security Act (42 U.S.C. 1320a–7e), report-

ing the existence of such conviction to the designated agency established under this section;

(v) determine which individuals are direct

patient access employees (as defined in para-

graph (6)(B)) for purposes of the nationwide program;

(vi) as appropriate, specify offenses, in-

cluding convictions for violent crimes, for purposes of the nationwide program; and

(vii) describe and test methods that re-

duce duplicative fingerprinting, including

providing for the development of "rap back" capability for the State such that, if a direct patient access employee of a long-term care facility or pro-

vider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, the designated agency shall match the prints on file with the State law enforcement department.
(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the recent direct access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy. Background screenings under this subsection shall be valid for a period of no longer than 2 years, as determined by the State and approved by the Secretary.

(6) Payments.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under section 1116(a)(3)(A)(i) of such Act (19 U.S.C. 1396d(d)), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be an amount that is equal to the Federal guarantee to make available under clause (I).

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (I).

(6) Definitions.—Under the nationwide program:

(A) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘long-term care facility or provider’ means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395f(a)));

(ii) An intermediate care facility for the mentally retarded (as defined in section 405(h)(4) of such Act (42 U.S.C. 1396n(1));

(iii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a)));

(iv) A home health agency;

(v) A provider of hospice care (as defined in section 1861(dd)(1)) of such Act (42 U.S.C. 1395x(dd)(1));

(vi) A long-term care hospital (as described in section 200x1(s) of such Act (42 U.S.C. 1395ww(d)(10))); and

(vii) A provider of personal care services.

(B) RESIDENTIAL CARE FACILITY.—A residential care facility that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a nursing home level of care, as approved by State licensure or State definition.

(IX) AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED.—(A) The term ‘intermediate care facility for the mentally retarded’ means such term as defined in section 1906(g)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1396d(g)(2)(B)(iii)).

(x) ANY OTHER FACILITY OR PROVIDER.—The term ‘other facility or provider’ means any facility or provider of long-term care services under such titles as the participating State determines appropriate.

PART 2—CIVIL MONEY PENALTIES

SEC. 1421. CIVIL MONEY PENALTIES.

(A) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1396l(h)(2)(B)(ii)) is amended to read as follows:

‘‘(II) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

‘‘(A) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III) for each day or instance, to a maximum of not more than $3050.

(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term ‘applicable per instance amount’ means—

(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000;

(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

(B) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

(C) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or equivalent of the facility, or if the deficiency is imposed for a deficiency described in subclause (II)(bb).

(V) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

(aa) subject to item (cc), shall, not later than 30 days after the imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established by the State, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for final recommendations for such penalties;

(bb) in the case where the penalty is imposed for each day of noncompliance, shall not assess a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date on which the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals; and

(ee) in the case where the facility successfully appeals the penalty, may provide for
the return of such amounts collected (plus interest) to the facility; and

‘‘(ft) in the case where all such appeals are unsuccessful, may provide that some portion of such appeals may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).”

‘‘(1) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

‘‘(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(I) or (ii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

‘‘(III) LIMITATION ON AGGRAVATED REDUCTIONS.—The aggregate reduction in a penalty under clause (iii) shall not exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

(1) subject to subsection (III), shall, not later than 30 days after the date of imposition of the penalty, provide for the facility to participate in an independent dispute resolution process, established by the Secretary, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency, as established by the State, for the facility to participate in an independent dispute resolution process which generates a written record prior to the collection of such penalty;

(2) if the facility appeals the penalty, may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under subsection (I) is completed; or

(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subsection (I) is completed or the date that is 90 days after the date on which the informal dispute resolution process under subsection (I) is completed.

(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(V) if the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(VI) if the collection of such amounts collected is unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).

(2) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)(ii)) is amended by inserting—

‘‘(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

‘‘(I) AMOUNT.—Subject to subsection (II), the amount of a penalty may be reduced by not more than 50 percent for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subsection (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subsection (C), the State may not reduce such penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(III) PROHIBITION ON REDUCTION FOR REPEATED DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subsection (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subsection with respect to a repeat deficiency.

‘‘(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions relate to the application of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty imposed by the Secretary.

‘‘(VI) IN CERTAIN CIRCUMSTANCES.—The amount of a penalty may be reduced (plus interest) to the facility; and

‘‘(VII) in the case where all such appeals are unsuccessful, may provide that some portion of such appeals may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).”

(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions relate to the application of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty imposed by the Secretary.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(2) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)) is amended by inserting ‘‘(I) in each case of a deficiency where the facility is cited for actual harm or immediate harm, an amount not less than $250 and not to exceed $100,000; and

(II) in each case of a deficiency where the facility is cited for actual harm or immediate harm, an amount not less than $3,050 and not more than $25,000; and

(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $5,000.”

(3) APPLICABLE PER INSTANCE AMOUNT.—In this subsection, the term ‘‘applicable per instance amount’’ means—

‘‘(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

‘‘(II) in each case of a deficiency where the facility is cited for actual harm or immediate harm, an amount not less than $3,050 and not more than $25,000; and

‘‘(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $5,000.

(4) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term ‘‘applicable per day amount’’ means—

‘‘(I) in each case of a deficiency where the facility is cited for actual harm or immediate harm, an amount not less than $3,050 and not more than $25,000 and

‘‘(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $5,000.

(5) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to the following:

‘‘(1) Penalties imposed by the Secretary for deficiencies for which a penalty was imposed under subsection (C) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

‘‘(2) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

‘‘(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(I) or (ii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

‘‘(III) LIMITATION ON AGGRAVATED REDUCTIONS.—The aggregate reduction in a penalty under clause (iii) shall not exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

(1) subject to subsection (III), shall, not later than 30 days after the date of imposition of the penalty, provide for the facility to participate in an independent dispute resolution process, established by the Secretary, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency, as established by the State, for the facility to participate in an independent dispute resolution process which generates a written record prior to the collection of such penalty;

(2) if the facility appeals the penalty, may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under subsection (I) is completed or the date that is 90 days after the date on which the informal dispute resolution process under subsection (I) is completed.

(3) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under subsection (I) is completed or the date that is 90 days after the date of the imposition of the penalty;

(4) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(5) if the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(6) if the collection of such amounts collected is unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).


‘‘(I) AMOUNT.—Subject to subclause (II), the amount of a penalty may be reduced by not more than 50 percent for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subsection (C), the State may not reduce such penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

‘‘(III) PROHIBITION ON REDUCTION FOR REPEATED DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

‘‘(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions relate to the application of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty imposed by the Secretary.

(7) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)(ii)) is amended by inserting—
manner as such provisions apply to a penalty or proceeding under section 1128(a)."

(b) CONFORMING AMENDMENT.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1395i–3(h)(8)) is amended by inserting "and in paragraph (3)(C)(ii)" after "paragraph (2)(A)."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the "pilot program") to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(b) REQUIREMENTS.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

(ii) subject to subsection (b), not later than the date that is 60 days prior to the date of such closure; and

(II) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

(ii) ensure that the facility does not make any new admissions or discharges; and

(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility, as determined by the Secretary, subject to subsection (c)(7), shall terminate; and

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, at the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) and during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

(3) SECERTARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395 et seq.).

(5) RESIDENTS RELOCATED.—The Secretary may, at the Secretary determines appropriate, make payments to the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

(II) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

(II) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;
has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successful.

(c) Effective date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION

(a) Skilled Nursing Facilities.—Section 1919(f)(2)(A)(i)(i) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(i)) is amended by inserting “(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)” after “curriculum”.

(b) Nursing Facilities.—Section 1919(f)(2)(A)(i)(i) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(i)) is amended by inserting “(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)” after “curriculum”.

(c) Effective date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISING STAFF.

(a) Study.—

(1) In general.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities.

(b) Effective date.—The study shall be completed by not later than one year after the date of the enactment of this Act.

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

(a) Establishment of requirements.—The Secretary shall establish and periodically update standards and requirements for ensuring, in the case of ongoing training, dementia management training and resident abuse prevention training, the quality of training provided by nursing facilities and certified nurse aides who are providing care to residents of such facilities.

(b) Effective date.—The amendments made by this section shall take effect 180 days after the date of enactment of this Act.

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

SEC. 1443. QUALIFICATION OF DIRECTOR OF FOOD SERVICES OF A SKILLED NURSING FACILITY OR NURSING FACILITY

(a) Medicare.—Section 1819(b)(4)(A) of the Social Security Act (42 U.S.C. 1395i–3(b)(4)(A)) is amended by adding at the end the following:

(2) Qualification of director of food services of a skilled nursing facility or nursing facility.
"E) health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language; and
"F) the efficiency and resource use in the provision of care.
"(2) USE OF FUNDS.—An entity that enters into an agreement under subsection (a) shall develop quality measures that: 
"(A) that may be used to provide outcome data that is consistent with subsection (b); and
"(B) are available, out of any funds in the Treasury not otherwise appropriated, to the Secretary for purposes of carrying out this subsection.
"(3) AVAILABILITY OF MEASURES.—The Secretary shall not fund the development of quality measures developed under this section available to the public.
"(4) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures developed under this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, to the Secretary for purposes of carrying out this subsection.
"(5) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of newly developed quality measures.
"(6) APPLICATION FOR GRANT.—A grant may be made under this section available, out of any funds in the Treasury not otherwise appropriated, to an eligible entity that has entered into a contract with the Secretary for purposes of developing quality measures.
"(7) FUNDING.—
"(A) IN GENERAL.—In making payments, the Secretary shall consider—
"(B) AUTHORIZATION OF APPROPRIATIONS.—
"(I) Subject to subclause (II), for purposes of preparing and implementing the rulemaking process, the Secretary shall make available, out of any funds in the Treasury not otherwise appropriated, to the Secretary for purposes of carrying out this subsection, an amount equal to $1,000,000 for each of the fiscal years 2010 through 2014.
"(II) The Secretary shall include in the annual budget request submitted to Congress for fiscal year 2010 and each subsequent fiscal year a request for the support of the rulemaking process.
"(8) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—The Secretary shall make public any rulemaking process that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus process, as such processes are made available to the Secretary.
"(9) REPORT ON QUALITY MEASURES.—The Secretary shall submit a report to Congress at the end of the 15th calendar year following the end of the fiscal year of the submission of the first report under this subsection, on the status of the implementation of the requirements of this subsection, including—
"(A) a summary of the quality measures that have been endorsed by the Secretary, including the extent to which the measures have been endorsed by a consensus process;
"(B) a summary of the quality measures that have not been endorsed by the Secretary and the reasons for the lack of endorsement, including the extent to which the measures have been developed by entities and organizations that are related to the Secretary, to the extent practicable.
"(10) DUTIES OF SECRETARY.—The Secretary shall make public, out of any funds in the Treasury not otherwise appropriated, to the Secretary for purposes of carrying out this subsection, such amounts as the Secretary determines appropriate, of $1,000,000, to the Secretary for purposes of preparing and implementing the rulemaking process, the Secretary shall make available, out of any funds in the Treasury not otherwise appropriated, to the Secretary for purposes of carrying out this subsection.
provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary such information as the Secretary shall require, the following information with respect to the preceding calendar year:

(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier;

(B) With respect to the payment or other transfer of value, other than a drug sample—

(i) its value and date;

(ii) the name of the related drug, device, or supply, if available, to the level of specificity available; and

(iii) a description of its form, indicated (as appropriate) as—

(1) cash or a cash equivalent;

(2) in-kind items or services;

(3) stock, a stock option, dividend, profit, or other return on investment; or

(4) any other form (as defined by the Secretary).

(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

(3) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value made by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENT.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical investigation performed by an applicable manufacturer or distributor during the preceding calendar year, the applicable manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENT.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with the development of a new device, drug, device, biological, or medical supply, the applicable manufacturer or distributor shall report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

(B) Two calendar years after the date such payment or other transfer of value was made.

(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until after the date on which the information is no longer available to the public under such paragraph.

(7) PHYSICIANS IN SELF-INSURED HEALTH PLANS.—Notwithstanding any other provision of law, there shall be constructed to require the disclosure of a payment or other transfer of value to a physician by a self-insured health plan.

(8) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS.—

(1) HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization) that bills the Secretary under part A or part B of title XVIII for services furnished in connection with the ownership or investment shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity.

(2) ADDITIONAL PHYSICIAN OWNERSHIP.—

Not later than March 31 of each year (beginning with 2011), in addition to the requirement under subsection (a)(1), any applicable manufacturer, applicable group purchasing organization, or applicable distributor shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a)) in the applicable manufacturer, applicable group purchasing organization or applicable distributor during the preceding year:

(A) The dollar amount invested by each physician holding such an ownership or investment interest.

(B) The value and terms of each such ownership or investment interest.

(C) Any payment or other transfer of value provided to or received from such physician or holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such ownership or investment interest), including the information described in clauses (i) through (iii) of paragraph (a)(1)(B), and information described in subsection (a)(8)(A) and (a)(8)(B).

(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

(9) Disclosure.—In this subsection:

(A) PHYSICIAN.—The term 'physician' includes a physician's immediate family members (as defined for purposes of section 1871).

(B) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means any organization (as defined for purposes of section 1877) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply.

(C) ENTITY.—The term 'entity' includes any person, partnership, or association, and any other organization or group of persons engaged in any activity described in paragraphs (a)(1)(A), (a)(1)(B), and (a)(8)(A) and (a)(8)(B).

(D) REPORTING.—In this section:

(1) A person shall report information to the Secretary under this section not later than March 31, 2011, and annually thereafter, each applicable manufacturer or distributor that produces a drug, device, biological, or medical supply, or sells, leases, or provides a drug, device, biological, or medical supply, that sells, leases, or provides a drug, device, biological, or medical supply.

(2) A person shall report information to the Secretary under this section not later than March 31, 2011, and annually thereafter, each applicable group purchasing organization that arranges for the purchase of a drug, device, biological, or medical supply.
providing advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries under title XVIII. The study shall be completed and submitted to Congress by January 1, 2012.

"(c) PUBLIC AVAILABILITY.—

"(1) IN GENERAL.—The Secretary shall establish procedures to ensure that not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under subsections (a) and (b), other than with regard to drug samples, with respect to the preceding calendar year is made available through an Internet website that—

"(A) is searchable and is in a format that is clear and understandable;

"(B) contains information that is presented in the name of the applicable manufacturer, distributor, or other entity regarding the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, the percentage of the total annual revenues of the reporting entity (as appropriate) under subsection (a)(1)(B)(iii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

"(C) contains information that is able to be easily downloaded in an electronic format;

"(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d) during the preceding year;

"(E) contains background information on industry-physician relationships;

"(F) in the case of information submitted with regard to a covered drug, device, biological, or medical supply, such a drug, device, biological, or medical supply; and

"(G) contains any other information the Secretary determines would be helpful to the average consumer; and

"(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

"(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the reporting entity reporting under subsection (a) or (b), as applicable. The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the applicable reporting entity with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

"(3) USE OF FUNDING FOR DRUG SAMPLES.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

"(4) PENALTY FOR NONCOMPLIANCE.—Information relating to national provider identifiers.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

"(d) PENALTIES FOR NONCOMPLIANCE.—

"(1) FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any reporting entity that fails to submit information required under subsection (a) or (b), as applicable, to the Secretary in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $150,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A), with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $150,000.

"(2) KNOWING FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), any reporting entity that knowingly fails to submit information required under subsection (a) or (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A), with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $150,000.

"(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

"(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary and the reporting entity reporting under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against an applicable manufacturer or distributor in the State.

"(5) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

"(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

"(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

"(C) Definitions.—In this section:

"(i) APPLICABLE DISTRIBUTOR.—The term ‘applicable distributor’ means any entity that is other than an applicable group purchasing organization, that buys and resells, or receives a commission on or other consideration from, another entity, and which provides assistance or support to such entity so described with respect to the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, drug sample, device, biological, or medical supply.

"(ii) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means any entity other than a group purchasing organization that is engaged in the production, preparation, conversion, processing, marketing, or distribution of a covered drug, drug sample, device, biological, or medical supply.

"(iii) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term ‘applicable group purchasing organization’ includes any compensation, gift, honorarium, speaking fee, consulting fee, travel, dividend, dividend equivalent, stock or stock option grant, or any ownership or investment interest held by a physician in a
manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

**(C) EXCLUSIONS.—The term ‘payment or other transfer of value’ does not include the following:**

(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed §5.

(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(iii) Items or services provided under a contractual arrangement, including the remuneration of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(v) In-kind items used for the provision of charity care.

(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c)).

(vii) Compensation paid by an applicable manufacturer or distributor to a covered recipient by employees of such manufacturer or distributor who works solely for such manufacturer or distributor.

(viii) Payments made to a covered recipient by an applicable manufacturer or by a health plan affiliated with an applicable manufacturer for medical care provided to employees of such manufacturer or their dependents.

(ix) Any discount (including a rebate).

(x) Any payment or other transfer of value that is made to a covered recipient in direct or through an entity other than the applicable manufacturer in connection with an activity or service.

(xi) Any payment or other transfer of value that is made to a covered recipient in direct or through an entity other than the applicable manufacturer in connection with an activity or service.

(xii) In the case of an applicable manufacturer, any self-financed payment for the provision of health care to employees under the plan.

(9) PHYSICIAN.—The term ‘physician’ has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

(10) REPORTING ENTITY.—The term ‘reporting entity’ means—

(A) with respect to the reporting requirement under subsection (a), an applicable manufacturer or distributor of a covered drug, device, biological, or medical supply required to report under such subsection; and

(B) with respect to the reporting requirement under subsection (b), a hospital, other health care entity, applicable manufacturer, applicable distributor, or applicable group purchasing organization required to report physician ownership under such subsection.

(11) STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes a summary of the information submitted under subsections (a), (b), and (e) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

(12) RELATION TO STATE LAWS.—

(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or political subdivision of a State that requires an applicable manufacturer or distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information described in subsection (a) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any statute or regulation of a State or political subdivision of a State that requires any of the following:

(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

(B) The disclosure or reporting, in any format, of information described in subsection (a) (other than information described in clause (1) of subsection (f)(8)(C)).

(C) The disclosure or reporting, in any format, of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health care.

(13) ANNUAL REPORTS TO STATES.—Not later than December 31, 2011, the Secretary shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required by section 1886(h) of the Deficit Reduction Act of 2005. Such report shall be submitted to Congress not later than the date that is 6 months after the date such surveys are collected and shall be made publicly available on an Internet website of the Department of Health and Human Services.

(14) DATA DISCLOSURE.—Except for purposes of the information provided by the manufacturer to a covered recipient, any of the following:

(A) The number and types of health care-associated infections reported under subsection (a).

(B) The name and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers; and

(C) By demographic information.

(15) REPORTING ON HEALTH CARE-ASSOCIATED INFECIONS.
(4) The total increases or decreases in health care costs that resulted from increased or decreased rates of occurrence of each such type of infection during such year.

(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

(6) Health care-associated infection means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

(2) To meet such deadline, the Secretary may establish, and any conflict or overlap between the reporting required under such section and any other reporting systems managed, and Human Services shall submit to Congress a report on additional data.

(3) The term ‘health care-associated infection’ means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

(4) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraphs (4)(H)(i) and (4)(H)(ii) and to the extent the hospitals can remove resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of the applicable resident limit for such hospital.

(5) In general.—The Secretary shall give preference to hospitals that place greater emphasis upon training programs, such as family practice and general internal medicine.

(6) In general.—The Secretary shall give preference to hospitals that place greater emphasis upon training programs, such as family practice and general internal medicine.

(7) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act, as inserted by subsection (a) of this section, the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 18 months after the date of the enactment of this Act) or, if not submitted (subject to audit), as determined by the Secretary.

(8) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing program, the hospital is not reflected on the most recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident level that includes the additional residents attributable to the expansion, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

(b) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act (as inserted by subsection (a) of this section), the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) or, if not submitted (subject to audit), as determined by the Secretary.

(c) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a) of this section. Such report shall include a review of the appropriateness of the types of information required for submission, compliance with reporting requirements, the success of the validity procedures established, and any conflict or overlap between the reporting required under such section and any other reporting systems mandated by either the States or the Federal Government.

(d) REPORT ON ADDITIONAL DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a) of this section, the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) or, if not submitted (subject to audit), as determined by the Secretary.

(e) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which have been certified (as defined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

(f) PROGRAMS SUBJECT TO REDUCTION.—If a hospital’s reference resident level (specified in clause (i)) is less than the otherwise applicable resident limit (as defined in such paragraph), the hospital shall be subject to such reduction for portions of the cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(i) In general.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a temporary increase has been set and, if not submitted (subject to audit), as determined by the Secretary.

(ii) The Secretary shall give preference to hospitals that place greater emphasis upon training programs, such as family practice and general internal medicine.

(iii) The Secretary shall give preference to hospitals that place greater emphasis upon training programs, such as family practice and general internal medicine.

(iv) The Secretary shall give preference to hospitals that place greater emphasis upon training programs, such as family practice and general internal medicine.

(v) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (designated under section 332 of the Public Health Service Act) or a health professional shortage area (designated under section 221 of such Act).

(vi) The Secretary shall give preference to hospitals in States that have lower resident-population ratios (as determined by the Secretary) if the Secretary determines, in coordination with the Secretary of Health and Human Services, the relative need for additional primary care residents in such States based on the following criteria.

(1) The Secretary shall give preference to hospitals in States that have lower resident-population ratios (as determined by the Secretary) if the Secretary determines, in coordination with the Secretary of Health and Human Services, the relative need for additional primary care residents in such States based on the following criteria.

(2) The Secretary shall give preference to hospitals in States that have lower resident-population ratios (as determined by the Secretary) if the Secretary determines, in coordination with the Secretary of Health and Human Services, the relative need for additional primary care residents in such States based on the following criteria.

(3) The Secretary shall give preference to hospitals in States that have lower resident-population ratios (as determined by the Secretary) if the Secretary determines, in coordination with the Secretary of Health and Human Services, the relative need for additional primary care residents in such States based on the following criteria.

(4) The Secretary shall give preference to hospitals in States that have lower resident-population ratios (as determined by the Secretary) if the Secretary determines, in coordination with the Secretary of Health and Human Services, the relative need for additional primary care residents in such States based on the following criteria.
(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(vi) APPLICABILITY OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the applicable PT resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under subsection (b) of section 1886(h) for that hospital as of July 1, 2011.

(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph beginning before July 1, 2011.

(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

(1) The term ‘resident level’ has the meaning given such term in paragraph (C)(1).

(2) The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(D) PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subsection (b) to:

(1) to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs; and

(2) as a condition of payment for a reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

(1) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(1)) before receiving such additional positions in such year; and

(2) the number of such additional positions.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)), in the third sentence, is amended—

(A) by striking ‘‘(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph beginning before July 1, 2011.‘’

(B) the number of primary care residents of the center shall not count against the contractor’s resident limit; and

(C) the contracting hospital shall agree not to count the time spent by a resident in a nonprovider setting, such as a Federally qualified health center or rural health clinic (as defined in section 1861(aa) of the Social Security Act), toward the determination of the resident’s time in its primary care residency training program.

(3) APPROVED TEACHING HEALTH CENTER DEFINED.—In this subsection, the term ‘approved teaching health center’ means an entity that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

SEC. 1506. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking ‘‘Such rules’’ and inserting ‘‘Subject to clause (ii), such rules’’; and

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

(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall ensure that all time that is spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or care of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency:.

(2) in paragraph (4), by adding at the end the following new subparagraph:

(ix) PROVISIONS OF PARAGRAPH (9)(A) APPLIED FOR GRAMING.—In determining the hospital’s number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or any other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is involved in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency:.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)), as amended by section 1501(b), is amended by adding at the end the following new clause:

(xii) PROVISIONS OF PARAGRAPH (9)(A) APPLIED FOR GRAMING.—In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in nonpatient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the
hospital shall be counted toward the determination of full-time equivalency if the hospital—
(i) is recognized as a subsection (d) hospital;
(ii) is a Puerto Rico hospital;
(iii) is reimbursed under a reimbursement system under section 1814(b)(3); or
(iv) is a provider-based hospital outpatient department.

‘‘(III) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.’’.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to—

(a) to apply to cost reporting periods beginning on or after January 1, 1983.

(b) to apply to cost reporting periods beginning on or after July 1, 2008.

(c) to apply to cost reporting periods beginning on or after October 1, 2001. Such section (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2008.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, so as added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(3) IMPRE.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after January 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a previously proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(h)(5)(B)(ii) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 1504. PRESERVATION OF RESIDENT CAP POLICY FOR ENGAGED HOSPITALS.

(a) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(E)(ii)) is amended by adding at the end the following new subparagraph:

‘‘(v) Redistribution of Residency slots after a hospital closes.—

(1) In general.—The Secretary shall, by rule, develop a process for hospitals that close with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State, closest closes on or after the date that is 2 years before the date of the enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

(II) Process for hospitals in certain areas.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the State. Such process shall take into consideration the recommendations submitted to the Secretary by the Osteopathic Physicians and Surgeons of America (as designated by the executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital’s closure, or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause, 180 days after such date of enactment.

(III) Limitation.—The estimated aggregate number of increases in the otherwise applicable resident limit under this paragraph shall equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(b) No effect on temporary FTE cap adjustments.—The amendments made by this section shall not affect any temporary adjustments under section 413.79(h) of title 42, Code of Federal Regulations, (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking ‘‘(7)’’ and inserting ‘‘(7) and’’.

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by inserting ‘‘or under paragraph (4)(H)(vi)’’ after ‘‘under paragraph (4)(H)(v)’’.

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY PROGRAMS.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—

Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with ‘‘(Notwithstanding’’ as a subparagraph (A) with the heading ‘‘IN GENERAL’’ and with appropriate indentation; and

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

‘‘(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—

The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

(i) Work effectively in various health care delivery settings, such as nonprovider settings.

(ii) Understand the relevant cost and value of various diagnostic and treatment options.

(iii) Work in interprofessional teams and across settings relevant to their specialties.

(iv) Work in multi-disciplinary team-based models in primary care.

(v) Work in interprofessional teams and across settings relevant to their specialties.

(vi) Be meaningful EHR users (as determined under section 1848(o)(2)), there are hereby applicable resident limit under this paragraph.

(vii) Be meaningful EHR users (as determined under section 1848(o)(2)), there are hereby applicable resident limit under this paragraph.

(b) GAO STUDY OF EVALUATION OF TRAINING PROGRAMS.—

(1) In general.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1), as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have adequate faculty expertise to teach the topics required to achieve such goals.

(2) Report.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include any recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(a) increased funding of curriculum requirements; and

(b) assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse

SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO FIGHT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1317(k) of the Social Security Act (42 U.S.C. 1395ddd(k)) is amended—

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

‘‘ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraph (7), and any appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraph (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.’’;

(2) in paragraph (4)(A)—

(A) by inserting for activities described in paragraph (3)(C) and after ‘‘necessity’’; and

(B) by inserting ‘‘until expended’’ after ‘‘appropriation’’;

(3) in paragraph (5), by striking ‘‘or’’;

(4) in paragraph (7), by striking ‘‘or’’;

(5) in paragraph (8), by striking ‘‘or’’; and

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1123(a)(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) by paragraph (1)(B), by striking all that follows in which the person was excluded and inserting ‘‘under Federal law from the Federal health care program under which the claim was made or;’’

(2) by striking ‘‘or’’ at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end ‘‘or’’;

(4) by inserting after paragraph (7) the following new paragraph:

‘‘(k) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;’’.

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1612. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.
in cases under paragraph (7), $50,000 for each such act)’’ and inserting ‘‘in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (6), $50,000 for each false record or statement (or misrepresentation of a material fact)’’; and

(6) in the second sentence, by striking ‘‘for a lawful purpose’’ and inserting ‘‘for a lawful purpose, or in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation’’;

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF FALSE STATEMENTS MATERIAL TO A FALSE CLAIM.

(a) In General.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 1611, is further amended—

(1) in paragraph (7), by striking ‘‘or’’ at the end;

(2) in paragraph (8), by inserting ‘‘or’’ at the end;

(3) by inserting after paragraph (8), the following new paragraph:

‘‘(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;’’; and

(4) by amending the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking ‘‘or in cases under paragraph (8)’’ and inserting ‘‘in cases under paragraph (8);’’ and

(B) by striking ‘‘a material fact’’ and inserting ‘‘a material fact, in cases under paragraph (9), $50,000 for each false record or statement’’;

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) In General.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking ‘‘or’’ at the end;

(2) in paragraph (9), by inserting ‘‘or’’ at the end;

(3) by inserting after paragraph (9) the following new paragraph:

‘‘(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, and other statutory functions of the Inspector General of the Department of Health and Human Services;’’; and

(4) in the matter following paragraph (10), as amended by paragraph (3), by inserting ‘‘, or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph’’ after ‘‘false record or statement’’;

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1871(d)(2)(C) of such Act (42 U.S.C. 1395w–27(d)(2)(C)) is amended—

(1) in subparagraph (A), by inserting ‘‘timely’’ before ‘‘inspect’’; and

(2) in subparagraph (B), by inserting ‘‘timely’’ before ‘‘audit and inspect’’.

(c) Enforcement.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE PROGRAM SAFE-GUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1860E(g)(1)(A), the following new section:

‘‘SEC. 1818A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

‘‘(a) In General.—If the Secretary determines, or in cases under paragraph (8), otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and fails to correct such deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (A)

‘‘(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (A)

‘‘(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;’’; and

(b) Application to Medicaid.—Section 1819A of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

‘‘(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.’’.

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) In General.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking ‘‘or’’ at the end of paragraph (9);

(2) by inserting ‘‘or’’ at the end of paragraph (10); and

(3) by inserting after paragraph (10) the following new paragraph:

‘‘(11) orders or prescribes an item or service, without limitation on home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or other necessary services, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or reasonably should know that the item or service will be presented to such a program;’’;

and

‘‘(v) in-service training for staff.

The provisions of section 1128A other than subsections (a) and (b) shall apply to a civil money penalty under clause (1) in the same manner as such provisions apply to a penalty under section 1128A. The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has made the necessary improvements to continue compliance with all requirements referred to in that clause.

(b) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedies available to an individual at common law.

(c) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

SEC. 1616. AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures respecting the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.’’.

(b) APPLICATION TO MEDICAID.—Section 1819A of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

‘‘(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.’’.

SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

‘‘The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.’’.

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) In General.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking ‘‘or’’ at the end of paragraph (9);

(2) by inserting ‘‘or’’ at the end of paragraph (10); and

(3) by inserting after paragraph (10) the following new paragraph:

‘‘(11) orders or prescribes an item or service, without limitation on home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or other necessary services, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or reasonably should know that the item or service will be presented to such a program;’’;

and

‘‘(v) in-service training for staff.

The provisions of section 1128A other than subsections (a) and (b) shall apply to a civil money penalty under clause (1) in the same manner as such provisions apply to a penalty under section 1128A. The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has made the necessary improvements to continue compliance with all requirements referred to in that clause.

(b) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedies available to an individual at common law.

(c) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

SEC. 1616. AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures respecting the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.’’.

(b) APPLICATION TO MEDICAID.—Section 1819A of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

‘‘(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.’’.

SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

‘‘The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.’’.
(4) in the matter following paragraph (1), as inserted by paragraph (2), by striking "$15,000 for each day of the failure described in such paragraph and inserting "$15,000 for each such failure described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual or entity, or in subparagraph (G), by striking ''or'' at the end; and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1616. ENHANCED PENALTIES FOR PROVIDE FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) In General.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—2(g)(2)(A)) is amended by inserting "except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination,"

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D MARKET PLANS.

(a) In General.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—2(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking "the effect of exclusion is", and inserting "the effect of exclusion is",

(2) by striking "that any employee or agent of such organization described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual or entity, or in subparagraph (G), by striking "or" at the end; and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) In General.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a-7(b)(2)) is amended—

(1) in the heading, by inserting "OR AUDIT" after "INVESTIGATION and inserting "INVESTIGATION or audit related to—"

(2) by inserting into the definition of," all that follows through the period and inserting "Investigation or audit related to—"

(i) any offense described in paragraph (1) or in subparagraph (a), or

(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128(b)(1))", and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) In General.—Section 1128(c) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking "AND PERIOD" and inserting "PERIOD, AND EFFECT";

and

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

"(d)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

(1) by an excluded individual or entity; or

(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

(3) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), the effect of exclusion is that no payment may be made by a Federal health care program for items or services (not including items or services furnished in an emergency department of a hospital) furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of such individual’s exclusion.

(4) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for items or services furnished by an excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services furnished by such excluded individual or entity to the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall be made for such items or services furnished by an excluded individual or entity to an individual eligible for such benefits, except as provided under subparagraph (C), for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

(5) (A) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for the items or services furnished by an excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services furnished by an excluded individual or entity to the individual eligible for such benefits at the time of such exclusion, payment shall be made for such items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

(6) (A) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for the items or services furnished by an excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services furnished by an excluded individual or entity to the individual eligible for such benefits at the medical direction or on the prescription of another individual eligible for such benefit during the period of such individual’s exclusion.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1620. OIG AUTHORITY TO EXCLUDE FROM FEDERAL HEALTH CARE PROGRAMS OFFICERS AND OWNERS OF ENTITIES CONVICTED OF FRAUD.

(a) Section 1128(b)(15)(A) of the Social Security Act (42 U.S.C. 1320a-7(b)(15)(A)) is amended—

(1) in clause (1)—

(A) by striking "has" and inserting "had"; and

(B) by striking "sanctioned entity and who knows or who should know (as defined in section 1128A(a)(6)(B))", and inserting "sanctioned entity and who knows or who should know (as defined in section 1128A(a)(6)(B))", and

(2) in clause (i)—

(A) by striking "is an officer" and inserting "was an officer"; and

(B) by inserting before the period the following: "at the time of the action constituting the basis for the conviction or exclusion described in subparagraph (B)".

SEC. 1621. SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) Development of Self-Referral Disclosure Protocol.—

(1) In General.—The Secretary of Health and Human Services, in collaboration with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) Publication on Internet Website of SRDP Information.—The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) Relation to Advisory Opinions.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(4) Cooperation in Providing Additional Information Related to the Disclosure.—The Secretary may provide such additional information to health care providers of services and suppliers making disclosures pursuant to an SRDP; and

(5) Types of Violations Reported Under the SRDP; and
(4) such other information as may be necessary to evaluate the impact of this section.

(d) RELATION TO OTHER LAW AND REGULATION.—Nothing in this section shall affect the application of section 1128G(c) of the Social Security Act, as added by section 1641, except, in the case of a health care provider of services or supplier who is a person (as defined in paragraph (4) of such section 1128G(c)) who discloses an overpayment (as defined in such paragraph) to the Secretary of Health and Human Services pursuant to paragraph (2) of such section 1128G(c), to extend such period described in paragraph (2) of such section 1128G(c) shall be extended with respect to the return of an overpayment to the extent necessary for the Secretary to determine pursuant to the SRDP the amount due and owing.

Subtitle C—Enhanced Program and Provider Protections

SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AUTHORITY.

(a) IN GENERAL.—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. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.

"(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORTATORIA.—

"(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines that there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other persons, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items and services (including a category described in paragraph (1), after the initial period such additional period of oversight is necessary.

"(2) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, or that the enrollment of providers of services and suppliers within a category of providers of services and suppliers (including a category with respect to the return of an overpayment to the extent necessary for the Secretary to determine pursuant to the SRDP the amount due and owing) such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

(5) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CATEGORIES OF PROVIDERS AND SUPPLIERS.—For periods beginning after January 1, 2011, if the Secretary determines under paragraph (1) that there is a significant risk of fraudulent activity among providers of medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII, if the Secretary determines that there is an initial enrollment under such title, the Secretary shall, notwithstanding section 1128G(c), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first finding by the Secretary that such supplier is within a category for durable medical equipment furnished by such supplier.

(6) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (2), by striking the semicolon at the end the following: "or", and inserting in its stead "and"; and

(B) by inserting before the period the following: "or any determination made by the Secretary based on relevant complaints, reports, referrals by law enforcement or other persons, data analysis, trending information, or claims submissions (including a category described in paragraph (1), after the initial period such additional period of oversight is necessary.

(2) CHIP.—Subsection (d) of section 2102 of such Act (42 U.S.C. 1397bb) is amended by adding before the end the following new paragraph:

"(4) PROVIDE THAT THE STATE WILL ENFORCE ANY DETERMINATION MADE BY THE SECRETARY TO SUSPEND OR EXCLUDE ANY PROVIDER OR SUPPLIER DESCRIBED IN SUCH SUBSECTION (A) OF SUCH SECTION THROUGH THE USE OF THE APPROPRIATE PROCEDURES DESCRIBED IN THE SOCIAL SECURITY ACT."
enroll (or renew the enrollment of) a professional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) In General.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395dd(c)) is amended—

(1) in paragraph (3), by striking at the end "and" and

(b) by redesignating paragraph (4) as paragraph (5); and

(c) by inserting after paragraph (3) the following new paragraph:

"(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and"

(b) Reference to Medicaid Integrity Program.—For a similar provision with respect to the Medicaid Integrity Program, see section 1762.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE FRAUD AND ABUSE.

(a) In General.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)), as amended by section 1601 of the HITECH Act (Public Law 111–5), is further amended by adding at the end the following new paragraph:

"(4) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) In general.—The Secretary may not enroll (or renew the enrollment of) a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title if the provider of services or supplier fails to, subject to subparagraph (E), establish a compliance program that contains the core elements established under subparagraph (A) and is monitored in a manner satisfactory to the Secretary, that the provider or supplier has established such a program.

(B) EMBRACE OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education; reporting of fraud, waste, and abuse for the organization’s employees, and contractors; a confidential or anonymous mechanism, such as a hotline, to receive anonymous questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective actions; suspension or termination of potential offenses; and procedures to return all identified overpayments to the program under this title, title XIX, and title XXI.

(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under subparagraph (A) to which a provider of services or suppliers (other than physicians and skilled nursing facilities) shall be required to have established such a program for paragraph.

(D) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of services or suppliers (other than physicians and skilled nursing facilities) that the Secretary determines to be a category which is at high risk for fraud, waste, and abuse and for which risk reduction mechanisms, such as a hotline, or refund schemes in which the processing patterns of the Centers for Medicare & Medicaid Services are observed and exploited. Narrowing the window for claims processing will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. The window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, and D, of title XVII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not be shortened and providers will reduce fraud and abuse.
SEC. 1639. FACE-TO-FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE ELIGIBILITY CERTIFICATIONS FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding at the end the following new paragraph:

"(3) C LARIFICATION.—Repayment of any overpayment retained later than the date that is 90 days after the date of the determination that such services were furnished on or after January 1, 2012, shall be considered an overpayment for purposes of section 1128C(b)(5) of the Social Security Act, if the provider or supplier did not otherwise limit the provider or supplier's potential liability for administrative or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud or other intentional conduct by the provider or supplier or the employees or agents of such provider or supplier."
(C) by striking “or” at the end of paragraph (10);

(D) by inserting after paragraph (11) the following new paragraphs:

“(12) conspires to commit a violation of this section; or

“(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;” and

(E) in another following paragraph (13), as inserted by subparagraph (D)—

(i) by striking “or” before “in cases under paragraph (11)”; and

(ii) by inserting “, in cases under paragraph (12), $50,000 for any violation described in this section commenced in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease” after “by an excluded individual”; and

(F) in the second sentence, by striking “such false statement, omission, or misrepresentation” and inserting “such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section commenced in furtherance of the conspiracy involved; or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased”;

(2) in subsection (c)(1), by striking “six years” and inserting “10 years”; and

(3) in subsection (i)—

(A) by amending paragraph (2) to read as follows:

“(2) The term ‘claim’ means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 11238(f)), whether or not the United States or a State agency has title to the money or property, that—

“(A) is presented or caused to be presented to an agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

“(B) made by the contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program’s behalf or to advance a Federal health care program interest, and if the Federal health care program—

“(i) provides or has provided any portion of the money or property requested or demanded;

“(ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded;

“(B) by amending paragraph (3) to read as follows:

“(3) The term ‘item or service’ means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program;” and

(C) in paragraph (6)—

(i) in subparagraph (C), by striking at the end “or”;

(ii) in the first subparagraph (D), by striking at the end the period and inserting “; or”;

and

(iii) by redesignating the second subparagraph (D) as a subparagraph (E);

(D) by amending paragraph (7) to read as follows:

“(7) The terms ‘knowing’, ‘knowingly’, and ‘should know’ mean that a person, with respect to information—

“(A) has actual knowledge of the information;

“(B) acts in deliberate ignorance of the truth or falsity of the information; or

“(C) acts with reckless disregard of the truth or falsity of the information and require no proof of specific intent to defraud;”; and

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

“(8) The term ‘obligation’ means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensee-licensee relationship, from a farsighted or similar relationship, from statute or regulation, or from the retention of any overpayment.

“(9) The term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.”

SEC. 1646. REQUIRING PROVIDER AND SUPPLIER PAYMENTS UNDER MEDICARE TO BE MADE THROUGH DIRECT DEPOSIT OR EFT AT INSURED DEPOSITORY INSTITUTION.

(a) Medicare.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) Limitation on Payment to Providers of Services and Suppliers.—No payment shall be made under this title for items and services furnished by a provider of services or supplier unless each payment to the provider of services or supplier is in the form of direct deposit or electronic funds transfer to the provider’s account, as applicable, at a depository institution (as defined in section 1860(a)(1)(A) of the Federal Reserve Act) .

(b) Effective Date.—The amendments made by this section shall apply to each payment made to a provider of services, provider, or supplier on or after such date (not later than July 1, 2012) as the Secretary of Health and Human Services shall specify, regardless of whether or not such payment is made with funds from a Federal health program.

SEC. 1647. INSPECTOR GENERAL FOR THE HEALTH CHOICES ADMINISTRATION.

(a) Establishment.—There is hereby established an Office of Inspector General for the Health Choices Administration, to be headed by the Inspector General for the Health Choices Administration to be appointed by the President, by and with the advice and consent of the Senate.

(b) Access to the Inspector General Act of 1976.—

(1) Application to Health Choices Administration.—Section 12 of the Inspector General Act of 1976 is amended by adding at the end the following:

“(i) grants or 8H, or 8M’’.

(2) Special provisions relating to health choices administration and HHS.—The Inspector General Act of 1978 (5 U.S.C. App.) is further amended by inserting after section 8F the following new section 8H:

“SEC. 8H. SPECIAL PROVISIONS RELATING TO THE HEALTH CHOICES ADMINISTRATION AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

“(a) The Inspector General of the Health Choices Administration shall—

“(1) have the authority to conduct, supervise, and coordinate audits, evaluations, and investigations of the programs and operations of the Health Choices Administration established under section 241 of the Affordable Health Care for America Act, including matters relating to fraud, abuse, and misconduct in connection with the admission and continued participation of any health benefit plan participating in the Health Insurance Exchange established under section 331 of such Act;

“(2) have the authority to conduct audits, evaluations, and investigations relating to any private Exchange-participating health benefit plan, as defined in section 201(c) of such Act;

“(3) have the authority, in consultation with the Office of Inspector General for the Department of Health and Human Services and subject to such conduct audit, evaluations, and investigations relating to the public health insurance option established under section 321 of such Act; and

“(4) have access to a depository institution necessary to carry out this section, including records relating to claims paid by Exchange-participating health benefit plans.

“(b) Authority granted to the Health Choices Administration and the Inspector General of the Health Choices Administration by the Affordable Health Care for America Act does not include any authorities, and responsibilities of the Office of Inspector General for the Department of Health and Human Services, and in existence as of the date of the enactment of the Affordable Health Care for America Act, to oversee programs and operations of such program. The Office of Inspector General for the Department of Health and Human Services retains primary jurisdiction over fraud and abuse in connection with payments made under the public health insurance option established under section 321 of such Act and administered by the Department of Health and Human Services.”

“(c) Application by Rule of Construction.—Section 8J of the Inspector General Act of 1978 (5 U.S.C. App.) is amended by striking “or 8H” and inserting “, 8H, or 8M’’.

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

(a) GAO Access.—Subchapter II of chapter 7 of title 31, United States Code, is amended by adding at the end the following:

“(7) 721. Access to certain information

“No provision of the Social Security Act shall be construed to limit, amend, or supersede the authority of the Comptroller General to obtain any information, to inspect any record, or to interview any officer or employee under section 720, with respect to any information disclosed to or obtained by the Secretary of Health and Human Services under part C or D of title XVII of such Act.”

(b) Access to Medicare Part D Data Program Integrity Purposes.—
be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Provided, that the information described in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report) a violation of a condition of treat- ment of the information specified in this sec- tion.

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HHS OFFICE OF THE INSPECTOR GEN- ERAL.—Section 1128C(a)(1) of the Social Secu- rity Act (42 U.S.C. 1320a–7c(a)(1)) is amend- ed—

(1) in subparagraph (C), by adding at the end “and”;

(2) in subparagraph (D), by striking at the end “and” and inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Veterans Affairs at the request of a Veterans Health Administration entity or entity under the preceding provisions of this sec- tion, have been available to the Secretary

(2) by adding “or” at the end of sub- clause (VI); and

(b) by adding “or” at the end of subclause (VII); and

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

“(VII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures speci- fied by the Secretary in consultation with the Health Choices Commissioner) does not exceed 150 percent of the income official poverty line (as defined by the Office of Manage- ment and Budget, and revised annually in ac- cordance with section 205(h) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;”;

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1395b(a)(10)(A)(1)) is amended—

(A) in clause (iii), by striking “and” at the end; and

(B) in clause (iv), by adding “and” at the end;

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

“(v) for making medical assistance available for medical cost-sharing described in subparagraphs (B) and (C) of section 1905(c), for individuals who would be qualified medicare bene- ficiaries described in section 1905(p)(1) but that their income exceeds the in- come level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size in- volved; and”;

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Sec- tion 1902(a)(10)(E) of such Act (42 U.S.C. 1396a(b)(4)(G)) is amended—

(A) in the first sentence of subsection (b), by striking “and” before “(4)” and by insert- ing “and” after clause (3) of such section but before “(5)”;

(b) by adding “or” and “inserting a period; and

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

“(5) 100 percent (for periods begin- ning after July 1, 2011, shall prominently dis- play in a manner prescribed by the Secretary a separate toll-free telephone number main- tained by the Secretary for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.”;

(b) CONFORMING AMENDMENTS.—Section 1804(c) of the Social Security Act (42 U.S.C. 1395b–2(c)) is amended—

(1) in paragraph (2), by adding “and” at the end;

(2) in paragraph (3), by striking “and” and inserting a period; and

(3) by striking paragraph (4).

TITLE VII—MEDICAID AND CHIP

Subtitle A—Medicaid and Health Reform

SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(b) ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) IN GENERAL.—To eliminate duplication between the Healthcare Integrity and Pro- tection Data Bank (HIPDB) established under section 1128E of the Social Security Act and the National Practitioner Data Bank (NPDB) established under the Health Care Quality Improvement Act of 1986, sec- tion 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) in subsection (a), by striking “Not later than” and inserting “Subject to subsection (b), not later than;”;

(2) in the first sentence of subsection (d)(2), by striking “other than with respect to re- quests made by” and inserting “other than requests made by”;

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

“(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK: TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Secretary shall imple- ment a process to eliminate duplication be- tween the Healthcare Integrity and Protec- tion Data Bank (in this subsection referred to as the ‘NPDB’) as implemented under the Health Care Quality Improvement Act of 1986 and standards promulgated pursuant to such Act, including the data elements necessary to ensure that information formerly collected in the HIPDB will
with 2015) with respect to amounts described in subsection (y); and

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

“(y) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ‘‘or (IX)’’ after ‘‘(VIII)’’.

(b) By striking ‘‘Section 1902(a)(10)(A)(i)(X), Special 1902(a)(10)(A)(i)(XI), and 1902(a)(10)(A)(i)(XII) eligibility and, with the individual’s authorization, the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.’’.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SECTION 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—Title XIX of the Social Security Act is amended by adding at the end the following new section:

“SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—The State shall enter into a Medicaid memorandum of understanding with an Exchange and the memorandum.

(b) Exchange-Eligible Individuals.—A State shall not do any redeterminations of eligibility for such individuals unless the period for redeterminations is consistent with the periodicity for redeterminations by the Commissioner of eligibility for affordability credits under the Affordable Health Care for America Act, as specified under such memorandum.

(c) Determinations of Eligibility for Affordability Credits.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under title II of the Affordable Health Care for America Act, under such memorandum.

(d) Exchange-Eligible Individuals.—Pursuant to such memorandum, the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(e) Application Process.—Such memorandum shall include such additional provisions as are necessary to implement effectively the provisions of this section and title II of division A of the Affordable Health Care for America Act.

(f) Additional Terms.—Such memorandum shall provide for

(1) the provisions of this section and title II of division A of the Affordable Health Care for America Act to be a Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in paragraph (2) of such section, of the child’s eligibility for medical assistance under this title.

(g) Determination of Eligibility and Coverage.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under title II of the Affordable Health Care for America Act, the State shall refer the individual to the Commissioner for the purposes of enrolling in a Medicaid program with such exchange and affordability credits, and for coverage under affordability credits, the State shall forward the information on the basis of which such determination made to the Commissioner; and

(h)Exchange-Eligible Individuals.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits, the provisions of this section and title II of division A of the Affordable Health Care for America Act, under such memorandum.

(1) the provisions of this section and title II of division A of the Affordable Health Care for America Act to be a Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in paragraph (2) of such section, of the child’s eligibility for medical assistance under this title.

(2) Extension of Exchange-Eligible Individuals.—In accordance with paragraph (1) of the Affordable Health Care for America Act, in the case of a child described in paragraph (1) of such section who at the end of the period referred to in paragraph (2) of such section, the child shall be deemed (until such time as

SECTION 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—Title XIX of the Social Security Act is amended by adding at the end the following section:

‘‘(3) Determinations of eligibility for affordability credits. — If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under title II of division A of the Affordable Health Care for America Act, under such memorandum.

(b) Exchange-Eligible Individuals.—Pursuant to such memorandum, the State shall accept without further determination the enrollment under this title of a child determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—The State shall enter into a Medicaid memorandum of understanding with such exchange and the memorandum.

(b) Exchange-Eligible Individuals.—A State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SECTION 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—The State shall enter into a Medicaid memorandum of understanding with such exchange and the memorandum.

(b) Exchange-Eligible Individuals.—A State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SECTION 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—The State shall enter into a Medicaid memorandum of understanding with such exchange and the memorandum.

(b) Exchange-Eligible Individuals.—A State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SECTION 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) In General.—The State shall enter into a Medicaid memorandum of understanding with such exchange and the memorandum.

(b) Exchange-Eligible Individuals.—A State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(c) Effective Date.—The amendments made by this subsection shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.
the child obtains such coverage or the State otherwise makes a determination of the child’s eligibility for medical assistance under its plan for this title pursuant to paragraph (2).”

(2) LIKELY TO END MEDICAID ELIGIBILITY—Paragraph (1) shall not be construed as preventing a State from imposing a limitation described in section 2110(b)(3)(C) for a fiscal year in order to terminate the child health plan under title XXI to those for which Federal financial participation is unavailable under section 2105 for the fiscal year.

(3) CHIP MOP TERMINATION DATE.—In paragraph (1), the ‘‘CHIP MOP termination date’’ for a State is the date that is the last day of Y1 (as defined in section 1002(c) of the Affordable Health Care for America Act).

(4) CHIP TRANSITION REPORT.—Not later than December 31, 2011, the Secretary shall submit to Congress a report:

(A) that compares the benefits packages offered under an average State child health plan under title XXI in 2011 and to the benefit standards initially adopted under section 224(b) of the Affordable Health Care for America Act and for affordability credits under subtitle C of title II of division C of such Act; and

(B) that includes such recommendations as may be necessary to ensure that—

(i) such coverage is at least comparable to the coverage provided to children under such an average State child health plan; and

(ii) there are procedures in effect for the enrollment of CHIP enrollees (including CHIP-eligible pregnant women) at the end of Y1 under this title, into a qualified health benefits plan offered through the Health Insurance Exchange, or into other acceptable coverage (as determined under such Act) without interruption of coverage or a written plan of treatment.

(5) MEDICAID MAINTENANCE OF EFFORT; SIMPLIFYING AND MODIFYING ELIGIBILITY RULES BETWEEN EXCHANGE AND MEDICAID.—

(1) IN GENERAL.—Section 1903 of such Act (42 U.S.C. 1396u–1(b)) is amended by inserting ‘‘subject to paragraph (5),’’ after ‘‘(A)’’.

(2) MINIMUM STANDARDS.—Effective January 1, 2013, any benchmark benefit package (or benchmark equivalent coverage under paragraph (2)) must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange.

(3) STANDARDS FOR BENCHMARK PACKAGES.—Section 1397(c) of such Act (42 U.S.C. 1397c–1(b)) is amended—

(A) in each of paragraphs (1) and (2), by inserting ‘‘subject to subsection (g),’’ after ‘‘section 1903(a)(2),’’; and

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

‘‘(5) MINIMUM STANDARDS .—Effective January 1, 2013, any benchmark benefit package (or benchmark equivalent coverage under paragraph (2)) must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange.’’

(4) REPORT OF CHIP.—Section 2104(a) of the Social Security Act is amended by inserting at the end the following:

‘‘No funds shall be appropriated or authorized to be appropriated under this section for fiscal years 2014 and 2015.’’

SEC. 1704. REDUCTION IN MEDICAID DSH.

(a) REPORT.—

(1) IN GENERAL.—Not later than January 1, 2012, the Secretary of Health and Human Services (in this title referred to as the ‘‘Secretary’’) shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reform carried out under division A in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing such report, the Secretary shall consult with community-based health care networks serving low-income beneficiaries.

(2) MATTERS TO BE INCLUDED.—The report shall include the following:

(A) RECOMMENDATIONS.—Recommendations regarding—

(i) the appropriate targeting of Medicaid DSH to the States; and

(ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the State to the number of uninsured individuals in such State.

(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform Methodology described in paragraphs (2) of subsection (b) for purposes of implementing the requirements of such subsection.
(3) COORDINATION WITH MEDICARE DSH REDUCTIONS.—The Secretary shall coordinate the report under this subsection with the report on Medicare DSH under section 1122.

(4) DSH RECOMMENDATIONS.—In this section, the term “Medicaid DSH” means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(A) IN GENERAL.—For each of fiscal years 2017 through 2019 the Secretary shall effect the following reductions:

(i) DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under paragraph (2) for the State for the fiscal year.

(ii) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) for each calendar quarter in the fiscal year, in the manner specified in subparagraph (C), in an amount equal to 4 of the DSH allotment reduction under clause (i) for the State for the fiscal year.

(B) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under subparagraph (A)(i) shall be equal to—

(1) $1,500,000,000 for fiscal year 2017;

(2) $1,650,000,000 for fiscal year 2018; and

(3) $6,000,000,000 for fiscal year 2019.

The Secretary shall distribute such aggregate reduction among States in accordance with paragraph (3).

(C) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under subparagraph (A)(ii) for a State for a quarter shall be deemed an overpayment to the State under section XIX(a)(3)(B), is amended—

(ii) hospitals that have high levels of unmet need for services or the availability of the needed services in the hospital; and

(3) by redesignating subparagraphs (F) through (K) as subparagraphs (F) through (J), respectively.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to expenditures made on or after July 1, 2010.

SEC. 1705. EXPANDED OUTSTATIONING.

(a) IN GENERAL.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by inserting “(A) in paragraph (27), by striking “and” at the end the following: ''; and (D) preventive services described in section 1790, the amendments made by this section shall apply to services furnished on or after July 1, 2010, with regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1712. TOBACCO CESSATION.

(a) DROPPING TOBACCO CESSATION EXCLUSIONS FROM COVERED OUTPATIENT DRUGS.—Section 2022(d)(3) of the Social Security Act (42 U.S.C. 1396r–8(d)(3)) is amended—

(1) by striking the first paragraph of subparagraph (C) and inserting “(C) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to expenditures made on or after July 1, 2010.

(b) ELIMINATION OF COST-SHARING.—Section 1794 of such Act (42 U.S.C. 1396l–4(f)) is amended by adding at the end the following paragraph:

(4) No hospital may be defined or deemed a disproportionate share hospital, or as an essential access hospital (for purposes of sub-section (a) or (r) that the Secretary determines the hospital to be an essential access hospital under this title or subsection (b) of this section (including any demonstration project under section 1115) unless the hospital—

(A) provides services to beneficiaries under this title without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary that the Secretary determines the hospital to be an essential access hospital under this title or subsection (b) of this section (including any demonstration project under section 1115) unless the hospital—

(B) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.

(2) EFFECTIVE DATE.—Except as provided in section 1706, the amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 1713. OPTION OF SELECTED NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1701(a)(5) of the Social Security Act (42 U.S.C. 1396a(a)(5)) is amended by striking “(A) in paragraph (27), by striking “and” at the end the following: ''; and (D) preventive services described in section 1790, the amendments made by this section shall apply to services furnished on or after January 1, 2010.

(b) ELIMINATION OF COST-SHARING.—Section 1794 of such Act (42 U.S.C. 1396l–4(f)) is amended—

(1) by striking subparagraph (C) and inserting “(C) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to expenditures made on or after July 1, 2010.

Briefly describe the main points of the amendment.

The amendment to Medicaid DSH reductions is a significant step towards reducing payments to states that have high levels of unmet need. This amendment will affect states for each fiscal year from 2017 to 2019, with the reductions increasing each year. The Secretary of Health and Human Services will distribute these reductions among states in a manner determined by the Secretary.

The amendment to the Tobacco Cessation exclusions from covered outpatient drugs will remove certain exclusions for tobacco cessation services, such as nicotine replacement therapy, hypnotherapy, or counseling. These services will be included in the Medicaid program starting on or after July 1, 2010.

The amendment to the Nurse Home Visitation Services will allow states to offer selected home visitation services to eligible families, including special home visits for newborn infants. These services will be included in the Medicaid program starting on or after January 1, 2010.
nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary, on evidence, that such services are effective in one or more of the following:

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

‘‘(2) Reducing the incidence of child abuse, neglect, and 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 and health assistance under the respective title, or as an administrative expenditure for which payment is made at a rate not in excess of 50 percent of the amount of the payment made under such Act, respectively, or on or after the date of the enactment of this Act.

SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDED GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(A) in subclause (XVIII), by striking ‘‘or’’ at the end; and

(B) in subclause (XIX), by adding ‘‘or’’ at the end; and

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

‘‘(XX) who are described in subsection (hh) (relating to individuals who meet certain income standards);’’.

(2) EFFECTIVE DATE.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1703, is amended by adding at the end the following new subsection:

‘‘(hh) Individuals described in this subsection are individuals—

‘‘(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

‘‘(B) who are not pregnant.

‘‘(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes in effect by that State for benefits described in clause (XV) of the matter following subparagraph (G) of subsection (a)(10) pursuant to a demonstration project waiver granted under section 1115.

‘‘(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for this subsection, the State may consider only the income of the applicant or recipient.’’.

(b) LIMITATION ON BENEFITS.—Section 1902(a)(10)(A)(ii) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended in the matter following subparagraph (G)—

(A) by striking ‘‘and (XIV)’’ and inserting ‘‘and (XIX)’’;

(B) by inserting ‘‘, and (XXV) the medical assistance made available to an individual described in subsection (hh) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting after ‘‘cervical cancer’’;

(4) CONFORMING AMENDMENTS.—Section 1906(a) of such Act (42 U.S.C. 1396d(a), as amended by section 1731(c), is amended in the matter preceding paragraph (1)—

(A) in clause (xiii), by striking ‘‘or’’ at the end;

(B) in clause (xiv), by adding ‘‘or’’ at the end; and

(C) by inserting after clause (xiv) the following:

‘‘(xv) individuals described in section 1902(hh).’’.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1926(b) the following:

‘‘PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

SEC. 1926C. (a) STATE OPTION.—State plan approved under section 1926 may provide for making medical assistance available to an individual described in section 1902(hh) relating to individuals who meet certain income eligibility levels for presumptive eligibility period. In the case of an individual described in section 1902(hh), such medical assistance shall be limited to family planning services described in 1905(a)(4)(C) and, at the State’s option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

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

‘‘(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(hh); and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

‘‘(2) QUALIFIED ENTITY.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

(i) is eligible for payments under a State plan approved under this title; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

‘‘(c) ADMINISTRATION.—

‘‘(1) In general.—The State agency shall provide qualified entities with—

‘‘(A) such forms as are necessary for an application to be made by an individual described in section 1902(hh), including, in the case of an entity described in subsection (a) for medical assistance under the State plan; and

‘‘(B) information on how to assist such individuals in completing and filing such forms.

‘‘(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

‘‘(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

‘‘(B) inform such individual at the time the determination is made that an application for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

‘‘(2) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

‘‘(3) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

‘‘(i) is furnished to an individual described in subsection (a)

‘‘(A) during a presumptive eligibility period;

‘‘(B) by a entity that is eligible for payments under the State plan; and

‘‘(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting ‘‘or’’ before the semicolon at the end the following: ‘‘and provide for making medical assistance available to individuals described in section (a) of section 1926C during a presumptive eligibility period in accordance with such section’’.

(B) Section 1902(a)(1)(D)(V) of such Act (42 U.S.C. 1396b(a)(1)(D)(V)) is amended—

(i) by striking ‘‘or’’ and inserting ‘‘and’’; and

(ii) by inserting before the period the following: ‘‘, or for medical assistance provided to an individual described in subsection (a) of section 1926C during a presumptive eligibility period under such section’’.

‘‘(4) CLARIFICATION OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396n-7(b)), as amended by section 1703(c)(2), is amended by adding at the end the following:

‘‘(6) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with this section.’’.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this title.

SEC. 1721. PAYMENTS TO PRIMARY CARE PROVIDERS.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b) as amended by sections 1703(a), 1714(a), 1731(a), and 1746, is amended—

(A) in subsection (a)(3)—

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

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

Subtitle C—Access

SEC. 1721. PAYMENTS TO PRIMARY CARE PROVIDERS.
(iii) by adding at the end the following new subparagraph:

"(C) payment for primary care services (as defined in subsection (kk)(1)) furnished by physicians, nurse practitioners, or any other health care professionals that would be primary care services under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary)."

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

"(kk) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13)(C):

(1) PRIMARY CARE SERVICES DEFINED.—The term ‘primary care services’ means evaluation and management services, without regard to whether such services are furnished by the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Care 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.

(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.

(3) CONSIDERATION FOR CERTAIN TECHNOLOGIES.—In considering applications for pilots projects under this section, the Secretary may approve a project which tests the effectiveness of application of new and innovative technologies, that are approved by the Food and Drug Administration and enable providers and practitioners to communicate directly with their patients in managing chronic illness.

(c) ADDITIONAL INCENTIVES.—In the case of a pilot project under subsection (a), the Secretary shall—

(1) waive the requirements of section 1902(a)(1) of the Social Security Act (relating to state-wideness) and section 1902(a)(10)(B) of such Act (relating to State plan applicability); and

(2) increase to up to 90 percent (for the first 2 years of the pilot program) or 75 percent (for the next 3 years) the matching percentage for the State plan as of June 16, 2009.

(d) MEDICALLY FRAGILE CHILDREN.—In the case of a model involving medically fragile children, the model should ensure that the patient or caregiver are able to obtain necessary transitional care if a child’s enrollment ceases for any reason.

(e) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the criteria described in section 1866F(e)(1) of the Social Security Act (as inserted by section 1123), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress a report on the findings of the evaluation under such paragraph.

(f) FUNDING.—The additional Federal financial participation for implementation of the pilot program under this section may not exceed in the aggregate $1,250,000,000 for the 5-year period of the program.

SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.

(a) IN GENERAL.—Section 1905(a)(2)(E) of the Social Security Act (42 U.S.C. 1396d(a)(2)(E)) is amended—

(1) by striking ‘‘and before ‘‘(B);’, and

(2) by inserting before the semicolon the following: ‘‘or before the semicolon the following: ‘‘(C) medical and other health services as defined in section 11901(a)(14) furnished by an optometrist (described in section 11901(a)(14)) to the extent such services may be provided under State law.”

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

SEC. 1724. OPTIONAL COVERAGE FOR FREE-STANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396c) is amended by adding after section 1713(a), as amended—

(1) in subsection (a)—

(A) by redesignating paragraph (29) as paragraph (30);

(B) in paragraph (28), by striking at the end ‘‘and’’; and

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

‘‘(29) freestanding birth center services (as defined in subsection (l)(3)(A) and other ambulatory services that are otherwise in-progress care for a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and’’; and

(2) in subsection (b), by adding at the beginning the following:

‘‘(C) The term ‘freestanding birth center’ means a health facility—

(i) that is not a hospital; and

(ii) that is not provider of care that is planned to occur away from the pregnant woman’s residence.’’

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of enactment of this Act.

SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER THE VACCINES FOR CHILDREN PROGRAM.


(1) by striking ‘‘or a rural health clinic’’ and inserting ‘‘or a rural health clinic’’; and

(2) by inserting ‘‘or a public health clinic,’’ after ‘‘1905(i)(1).’’

SEC. 1726. INCREASING COVERAGE OF SERVICES OF PODIATRISTS.

(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended—

(1) by striking ‘‘and before ‘‘(B);’’ and

(2) by inserting before the semicolon the following: ‘‘and before the semicolon the following: ‘‘(B) medical and other health services as defined in section 11901(a)(14) furnished by an optometrist (described in section 11901(a)(14)) to the extent such services may be provided under State law.”

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

SEC. 1726A. REQUISITE COVERAGE OF SERVICES OF OPTOMETRISTS.

(a) IN GENERAL.—Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396d(a)(5)) is amended—

(1) by striking ‘‘and before ‘‘(B);’’ and

(2) by inserting before the semicolon the following: ‘‘and before the semicolon the following: ‘‘(B) medical and other health services as defined in section 11901(a)(14) furnished by an optometrist (described in section 11901(a)(14)) to the extent such services may be provided under State law.”

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect 90 days after the
date of the enactment of this Act and shall apply to services furnished or other actions required on or after such date.

SEC. 1727. THERAPEUTIC FOSTER CARE.

(a) Therapeutic Foster Care—Nothing in this title shall prevent or limit a State from covering therapeutic foster care for eligible children in out-of-home placements under sections 1301 of the Social Security Act (42 U.S.C. 1396a(a)).

(b) Therapeutic Foster Care Defined.—For purposes of this section, the term "therapeutic foster care" means a foster care program that provides—

(1) to the child—

(A) structured daily activities that develop, reinforce, and reinforce appropriate social, communications, and behavioral skills;

(B) crisis intervention and crisis support services;

(C) medication monitoring; and

(D) counseling; and

(E) case management services; and

(2) established for payment by the parent and consultation with the foster parent on the management of children with mental illnesses and related health development and behavioral skills.

SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES.

(a) In General.—Title XIX of the Social Security Act is amended by inserting after section 1902 the following new section:

"SEC. 1903. QUALITY MEASURES FOR MENTAL HEALTH SERVICES UNDER MEDICAID.

"(a) General.—Under this title there shall be no quality measure developed, published, or standing any other provision in this Act, an irrebuttable presumption regarding either the quality of care or the maximum permissible coverage for any individual who receives medical assistance under title XIX or child health assistance under title XX.

"(b) Standardized Reporting Format.—No later than January 1, 2012, the Secretary shall develop and publish a standardized reporting format for use by State programs under titles XIX and XXI to collect data from managed care entities and providers and participants that furnish services through such programs and to report quality measures to the Secretary.

SEC. 1730. QUALITY MEASURES FOR MENTAL HEALTH SERVICES UNDER MEDICAID AND CHIP.

"(1) Development of Measures.—No later than January 1, 2011, the Secretary shall develop and publish for comment a proposed set of measures that accurately describe the quality of mental health care provided under State plans under titles XIX and XXI. The Secretary shall publish a final recommended set of such measures no later than July 1, 2011.

"(2) Standardized Reporting Format.—No later than January 1, 2012, the Secretary shall develop and publish a standardized reporting format for use by State programs under titles XIX and XXI to collect data from managed care entities and providers and participants that participate in such programs and to report quality measures to the Secretary.

SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

(a) In General.—The Secretary of Health and Human Services shall establish under this Act an accountable care organization program pilot program under which a State may apply to the Secretary for approval of an accountable care organization pilot program described in subsection (b) in this section referred to as a "pilot program." The Secretary shall establish the accountable care organization concept under title XIX of the Social Security Act.

(b) Pilot Program.

(1) In General.—The pilot program described in this subsection is a program that applies one or more of the accountable care organization models described in section 1866B of the Social Security Act, as added by section 1391 of this Act.

(2) Limitation.—The pilot program shall operate for a period of not more than 5 years.

(c) Additional Incentives.—In the case of the pilot program described in this section, the Secretary may—

(1) waive the requirements of—

(A) section 1902(a)(1) of the Social Security Act (relating to statewideness); and

(B) section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase the matching percentage for administrative expenditures up to—
Title IX—Medicaid Coverage

SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF WAIVER PERIODS FOR CERTAIN CHILDREN.

(a) In General.—Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397b(b)(1)) is amended by striking at the end of the following new paragraph:

"(v) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a child described in subparagraph (C);"; and

(b) Effective Date.—The amendments made by this section shall not apply to any child born after December 31, 2012.

Title X—Medicaid Coverage for Children

SEC. 1735. ADULT DAY HEALTH CARE SERVICES.

(a) In General.—The Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396a(a)) for the provision of day health care services, day activity, and health services, or adult day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if the adult day care services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan that provides for the provision of such services (by regulation or otherwise).

(b) Effective Date.—Subsection (a) shall apply with respect to services provided on or after October 1, 2008.

Title XIX—Medical Assistance for the Aged, Blind, and Disabled

SEC. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) In General.—Section 401(a) and paragraph (1) of section 401(a) of such Act (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

"(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the designated Federal program defined in paragraph (3)(C) (relating to the Medicaid program), section 401(a) and paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.".

Sec. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES—LIMITED EXEMPTION.

(a) Section 401(a) and section 401(b) of such Act (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking "or" at the end of the following paragraph:

"(i) INFANTS AND TODDLERS.—The child is under two years of age;"

(2) by inserting at the end of the following paragraph:

"(ii) LOSS OF GROUP HEALTH PLAN COVERAGE.—The child described in such subparagraph has lost group health plan coverage; or"

(3) by adding at the end the following:

"(iii) TERMINATION OF AN INDIVIDUAL'S EMPLOYMENT.—"(1) termination of an individual's group health plan or health insurance coverage offered through an employer;"

(4) the exception to 5-year limited eligibility provided in section 1613(d) is amended—

(1) in paragraph (1), by striking or "at the end of the following paragraph:

"(v) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a child described in subparagraph (C);"; and

(2) by adding at the end the following:

"(G) DESCRIPTION OF CHILDREN NOT SUBJECT TO WAITING PERIOD.—For purposes of this paragraph, a child described in this subparagraph is a child who, on the date an application is submitted for such child for child health assistance under this title, meets any of the following requirements:

"(i) INFANTS AND TODDLERS.—The child is under two years of age;"

(b) Effective Date.—The amendments made by this section shall take effect as of the date that is 90 days after the date of the enactment of this Act.
(3) by adding at the end the following:

“(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 436(a)(1)(C) of the Public Law 89–73, as designated Federal program defined in section 402(h)(3)(C) (replacing the Medicaid program).”

SEC. 1737. CONTINUING REQUIREMENT OF MEDICAID COVERAGE OF NON-EMERGENCY TRANSPORTATION TO MEET MEDICALLY NECESSARY SERVICES.

(a) REQUIREMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking “(21),” and inserting “(21), and (30)” ; and

(2) in subparagraph (C)(iv), by striking “(27)” and inserting “(17), and (30)”.

(b) DESCRIPTION OF SERVICES.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by sections 173(a)(1) and 1724(a)(1), is amended—

(1) in paragraph (29), by striking “and” at the end;

(2) by redesignating paragraph (30) as paragraph (31) during the comma at the end and inserting a semicolon; and

(3) by inserting after paragraph (29) the following new paragraph:

“(30) nonemergency transportation to medically necessary services, consistent with the requirement of section 431.53 of title 42, Code of Federal Regulations, as in effect as of June 1, 2008; and”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to transportation on or after such date.

SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME IN PROVIDING CONTINUING MEDICAID COVERAGE FOR CERTAIN INDIVIDUALS WITH EXTREMELY HIGH PRESCRIPTION COSTS.

Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by section 203(a) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new paragraph:

“(14) by striking the State, in the case of an individual with extremely high prescription drug costs described in subparagraph (B) who has been determined (without the application of such regulations) to be eligible for medical assistance under this title, the State may, in determining the individual’s eligibility for medical assistance under this title, disregard any family income of the individual to the extent such income is less than an amount that is specified by the State and does not exceed the amount specified in subparagraph (C), or, if greater, income equal to the cost of the orphan drugs described in subparagraph (B); and

“(B) An individual with extremely high prescription drug costs described in this subparagraph for a 12-month period is an individual—

(i) who is covered under health insurance or a health benefits plan that has a maximum lifetime limit of not less than $1,000,000 which includes all prescription drug coverage;

(ii) who has exhausted all available prescription drug coverage under the plan as of the beginning of the period such individual—

(1) by adding at the end the following:

“(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 436(a)(1)(C) of the Public Law 89–73, as designated Federal program defined in section 402(h)(3)(C) (replacing the Medicaid program).”

SEC. 1739. PROVISIONS RELATING TO COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS).

(a) COORDINATION WITH CLASS PROGRAMS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1831(b), 1708(a), 1729, 1753, 1757(a), 1758(a), 1758(a), and 1789(a), is amended—

(1) in paragraph (80), by striking “and” at the end;

(2) in paragraph (81), by striking the period and inserting “; and”;

(3) by inserting after paragraph (81) the following:

“(82) provide that the State shall comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXII of the Public Health Service Act as the Secretary shall establish.”.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by subsection (a), is amended—

(1) in paragraph (81), by striking “and” at the end;

(2) in paragraph (82), by striking the period at the end and inserting “; and”;

(3) by inserting after paragraph (82) the following:

“(83) provide that, not later than 2 years after the date of enactment of this paragraph, each State shall—

“(A) assess the extent to which entities such as providers of home care, home health services, personal care services, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXII of the Public Health Service Act, including in rural and underserved areas;

“(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas;

“(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such entities to inhibit such individuals relying on family members for the provision of personal care services.”.

SEC. 1739A. SENSE OF CONGRESS REGARDING COMMUNITY FIRST CHOICE OPTION TO PROVIDE MEDICAID COVERAGE OF COMMUNITY-BASED ATTENDING SERVICES AND SUPPORTS.

It is the sense of Congress that States should be allowed to elect under their Medicaid State plans under title XIX of the Social Security Act to implement a Community First Choice Option under which—

(1) coverage of community-based attendant services and supports furnished in homes and communities is available, at an individual’s option, to individuals who otherwise qualify for Medicaid institutional coverage under the respective State plan;

(2) such supports and services include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks;

(3) the Federal matching assistance percentage (FMAP) under such title for medical assistance for such supports and services is enhanced;

(4) States, consistent with minimum federal standards, ensure quality of such supports and services; and

(5) States collect and provide data to the Secretary of Health and Human Services on
the cost and effectiveness and quality of supports and services provided through such option.

Subtitle E—Financing

SEC. 1741. PAYMENTS TO PHARMACISTS.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended—

(A) by striking paragraph (5) and inserting the following:

“(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as 130 percent of the weighted average (determined on the basis of manufacturer-reported, monthly average manufacturer prices. Nothing in the previous sentence shall be construed as preventing the Secretary from performing such calculation using a smoothing process in order to reduce significant variations from month to month as a result of rebates, discounts, and other pricing practices, such as in the manner such a process is used by the Secretary in determining the average sales price of a drug or biological under section 1847A.”

(2) DEFINITION OF AMP.—Section 1927(c)(1)(B)(i) of such Act (42 U.S.C. 1396r–8(1)(B)(i)) is amended—

(B) in the heading, by striking “extended to wholesalers” and inserting “and other payments”;

(C) by striking “and to” and all that follows; and inserting the following: “and to”;

“(i) customary prompt pay discounts extended to wholesalers;

(2) in clause (ii), by striking “and other payments”;

(3) in clause (iii) by striking “and”;

(4) in clause (iv) by striking “discounts, and other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or other providers of prescription drugs, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

“(iv) sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or other providers of prescription drugs, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

“(v) sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions to obtain an accurate AMP for the drug. Such a determination shall not be subject to judicial review; or

“(vi) rebates, discounts, and other price concessions required to be provided under agreements under subsections (f) and (g) of section 1660D–2(d).”.

(3) MANUFACTURER REPORTING REQUIREMENTS.—Section 1927(c)(3)(A) of such Act (42 U.S.C. 1396r–8(3)(A)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) by striking the period at the end of clause (iii) and inserting “; and”;

(C) by inserting after clause (iii) the following:

“(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer’s total

number of the manufacturer’s claims, the average and

monthly average manufacturer price for each covered outpatient drug.”.

(4) AUTHORITY TO PROMULGATE REGULATIONS.—The Secretary of Health and Human Services may promulgate regulations to clarify the requirements for upper payment limits and to apply AMP in a manner that the Secretary determines will achieve the goal of making AMP available to States. Such regulations may become effective through December 31, 2010. The specific upper limit for each drug under section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), in the matter preceding clause (I), by inserting “month of” after “each”; and

(2) in paragraph (x)(v), by inserting “weighted” before “average manufacturer price.”

SEC. 1742. PRESCRIPTION DRUG REBATES.

(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

“(C) TREATMENT OF NEW FORMULATIONS.—In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

“(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

“(ii) the highest additional rebate (calculated as a percentage of the average manufacturer price under this section for any strength of the original single source drug or innovator multiple source drug; and

“(iii) the total costs of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).

In this subparagraph, the term ‘line extension’ means, with respect to a drug, a new formulation of the drug, such as an extended release formulation.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.

(b) INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(1)(B)(i)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (v), by striking “and before January 1, 2010” after “December 31, 1998”;

(2) INCREASE MINIMUM REBATE PERCENTAGE FOR INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1396r–8(1)(B)(ii)) is amended—

(A) in clause (i), by inserting “and before January 1, 2010” after “December 31, 1998”;

(B) by striking the period at the end of clause (ii) and inserting “; and”;

(C) by inserting after clause (ii) the following new clause:

“(VI) after December 31, 2009, is 23.1 percent.”;

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASED REBATES.—

(A) IN GENERAL.—The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

(B) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (1) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State’s quarterly disallowable Medicaid spending under section 1905(d)(2). Such a disallowance is not subject to a reconsideration under 1116(d).

SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396m(2)(A)) is amended—

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

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

(3) by adding at the end the following:

“(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as established by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1927(b)(2)(A) and to the Secretary under section 1927(b)(3), such information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this section.”

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—

(1) in the first sentence of subsection (b)(4), by inserting “or” at the end the following: “, including such drugs dispensed to individuals enrolled with a Medicaid managed care organization if the organization is responsible for coverage of such drugs”; and

(c) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

(1) IN GENERAL.—In addition to the amounts applied as a reduction under subsection (b), for rebates for periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

“(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

“(II) the amounts received by the State under such subparagraph that are attributable to the rebates (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by section 1743 of the Affordable Health Care for America Act, taking into account the additional drugs included under the amendments made by section 1743 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

(2) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (1) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State’s quarterly disallowable Medicaid spending under section 1905(d)(2). Such a disallowance is not subject to a reconsideration under 1116(d).
to an eligible dually-certified facility for a year under paragraph (1) shall remain available until all eligible dually-certified facilities that are subject to the requirements of paragraph (3) have been reimbursed for underpayments made before such date under this section.

(2) SUBMISSION OF INFORMATION.—For purposes of paragraph (1), payment amount determined by the Secretary, to—

(A) the State submits to the Secretary, in a timely manner and on an annual basis, the amounts available for obligation in the following years:

(i) $1,500,000,000 shall be available beginning in 2010.

(ii) $1,500,000,000 shall be available beginning in 2011.

(c) $1,500,000,000 shall be available beginning in 2012.

(D) $1,500,000,000 shall be available beginning in 2013.

(2) LIMITATION OF AUTHORITY.—The Secretary may not make payments under this section that exceed the funds appropriated under paragraph (1).

(3) DISPOSITION OF REMAINING FUNDS INTO MIF.—Any funds appropriated under paragraph (1) which remain available after the amounts described in subsection (b)(3) have been reimbursed for underpayments made before such date under this section, shall be available for obligation in the following years:

(A) $1,500,000,000 shall be available beginning in 2010.

(B) $1,500,000,000 shall be available beginning in 2011.

(C) $1,500,000,000 shall be available beginning in 2012.

(D) $1,500,000,000 shall be available beginning in 2013.

(4) USE OF FUNDS.—

(A) AUTHORITY TO MAKE PAYMENTS.—From the amounts available for obligation in a year under subsection (a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall pay the amount determined under paragraph (2) directly to each eligible dually-certified facility for the purpose of providing reimbursement to such facility for furnishing quality care to Medicare-eligible individuals.

(B) LIMITATION ON PAYMENT AMOUNT.—In no case shall the amount for such facility for the year be more than—

(i) 60 percent of the payment rate (excluding any supplemental payments) for such facility as reported on the facility’s latest available Medicare cost report.

(ii) the payment amount determined by the Secretary, to the Secretary’s satisfaction.

(C) PRO-RATA REDUCTION.—If the amount available for obligation under subsection (a) is more than the payment deficiency (as defined in subsection (b)(3)) available to such facility, the Secretary shall adjust the payment amount for such facility to—

(i) reduce the amount of the payment deficiency (as defined in subsection (b)(3)) available to such facility; and

(ii) reduce the amount of the payment deficiency (as defined in subsection (b)(3)) available to such facility for the preceding year by an amount equal to the payment amount determined by the Secretary for such facility for the preceding year.

(1) ANNUAL APPLICATIONS—

(A) The Secretary shall require an eligible dually-certified facility or a contractor designated by such facility to submit an annual application for all payments made in that fiscal year.

(B) The Secretary shall determine the fiscal year for which the application is made by the facility or an eligible dually-certified facility.

(C) The Secretary shall set the time for submission of the application for each fiscal year.

(1) ANNUAL APPLICATION—

(A) The Secretary shall require an eligible dually-certified facility or a contractor designated by such facility to submit an annual application for all payments made in that fiscal year.

(B) The Secretary shall determine the fiscal year for which the application is made by the facility or an eligible dually-certified facility.

(C) The Secretary shall set the time for submission of the application for each fiscal year.

(1) ANNUAL APPLICATION—

(A) The Secretary shall require an eligible dually-certified facility or a contractor designated by such facility to submit an annual application for all payments made in that fiscal year.

(B) The Secretary shall determine the fiscal year for which the application is made by the facility or an eligible dually-certified facility.

(C) The Secretary shall set the time for submission of the application for each fiscal year.

(2) PURPOSES—

(A) The Secretary shall require an eligible dually-certified facility or a contractor designated by such facility to submit an annual application for all payments made in that fiscal year.

(B) The Secretary shall determine the fiscal year for which the application is made by the facility or an eligible dually-certified facility.

(C) The Secretary shall set the time for submission of the application for each fiscal year.
deadlines, under which facilities may apply on an annual basis to qualify as eligible du-

tally-certified facilities for payment under subsection (b).

(2) Reporting Authority.—The Secre-
tary may enter into one or more contracts with en-
tities for the purpose of implementa-
tion of this section.

(3) Limitation.—The Secretary may not spend more than 0.75 percent of the amount made available under subsection (a) in any year on the costs of administering the pro-
gram of payments under this section for the year.

(4) Implementation.—Notwithstanding any other provision of law, the Secretary may imple-
ment, by program instruction or other-
wise, the provisions of this section.

(5) Limitations on Review.—There shall be no administrative or judicial review of—

(A) the determination of the amount of any payment made under subsection (b); or

(B) the determination of the amount of any payment made to a facility under such sub-
section.

(d) Annual Reports.—The Secretary shall submit an annual report to the committees
with jurisdiction in the Congress on pay-
ments made under subsection (b). Each such
report shall include information on—

(1) the facilities receiving such payments;

(2) the amount of such payments to such facili-
ties; and

(3) the basis for selecting such facilities and the amount of such payments.

(e) Reference to Report.—For report by the Medicaid and CHIP Payment and Access
Commission on the adequacy of payments to
nursing facilities under the Medicaid pro-
gram, see section 1900(b)(2)(B) of the Social
Security Act, as amended by section 1784.

(f) Definitions.—For purposes of this sec-
tion:

(1) Dually-Certified Facility.—The term “dually-certified facility” means a facility that
is participating as a nursing facility under title
XIX of the Social Security Act and as a skilled nursing facility under title
XVIII of such Act.

(2) Medicaid Eligible Individual.—The term “Medicaid eligible individual” means an
individual who is eligible for medical as-

socare, with respect to nursing

facilities, under title XIX of the Social Security Act, as amended by section 1784.

(g) State.—The term “State” means the 50
States and the District of Columbia.

SEC. 1746. REPORT ON MEDICAID PAYMENTS.

Section 1902 of the Social Security Act (42
U.S.C. 1396), as amended by sections 1703(a),
1714(a), and 1731(a), is amended by adding at
the end the following new subsection:

“(l) Report on Medicaid Payments.—
Each year, on or before a date determined by
the Secretary, a State participating in the
Medicaid program under this title shall sub-
mit to the Administrator of the Centers for
Medicare & Medicaid Services—

“(1) information on the determination of rates of payment to providers for covered
services under the State plan, including—

(A) the final rates;

(B) the methodologies used to determine such rates; and

(C) justifications for the rates; and

“(2) a description of the process used by the State to allow providers, beneficiaries
and their representatives, and other con-
cerned State residents a reasonable oppor-
tunity to comment on such rates, methodologys, and justifications before the
State made such rates final.”.

SEC. 1747. REVIEWS OF MEDICAID.

(a) Strengthening the Medicaid Program.—

(1) Study.—The Comptroller General of the
United States shall conduct a study regard-
ing federal payments made to the State Medi-
caid programs under title XIX of the Social
Security Act for the purpose of making rec-
ommendations to Congress.

(b) Reporting Authority.—The Comptroller General shall submit to the appro-
propriate committees of Congress a re-
port on the study conducted under paragraph (1) and the effect on the federal govern-
ment, States, providers, and beneficiaries of—

(A) removing the 50 percent floor, or 83 per-
cent ceiling, or both, in the Federal medical ex-

fluence percentage to better reflect State fiscal capacity and State effort to pay for health and long-term care
services and to better adjust for national or regional economic differences;

(B) revising the current formula for such Federal medical expenditure percentage to
better reflect State fiscal capacity and State effort to pay for health and long-term care
services and to better adjust for national or regional economic differences;

(c) GAO Study on Medicaid Administra-
tive Costs.—

(1) Study.—The Comptroller General of the
United States shall conduct a study of the
administration of the Medicaid program by
the Department of Health and Human Ser-

vices, State Medicaid agencies, and local govern-
ment agencies. The report shall address the
following issues:

(A) the extent to which federal funds for

such administrative expenditures such as survey
and certification and claims processing, are
being used effectively and efficiently;

(B) the administrative functions on which federal funds are expended and the
amounts of such expenditures (whether spent
directly or by contract).

(2) Report.—Not later than February 15,
2011, the Comptroller General shall submit to
the appropriate committees of Congress a re-
port on the study conducted under paragraph
(1).

SEC. 1748. EXTENSION OF DELAY IN MANAGED CARE ORGANIZATION PROVIDER TAX ELIMINATION.

Effective as if included in the enactment of
section 6651 of the Deficit Reduction Act of 2005 (Public Law 109-171), subsection (b)(2)(A) of
such section is amended by striking “Oct-
tober 1, 2009” and inserting “October 1, 2010.”

SEC. 1749. EXTENSION OF ARRA INCREASE IN FMAP.

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

(1) in subsection (a)(3), by striking “first
calendar quarter” and inserting “first 3 cal-

endar quarters”; and

(2) in subsection (b)(2), by inserting before
the end the following new paragraph:

“(77) provide that any provider or supplier
(other than a physician or nursing facility)
providing services under such plan shall, sub-
ject to paragraph (5) of section 1875(d), estab-
lish a compliance program described in para-
graph (1) of such section in accordance with
such paragraph.”.

SEC. 1754. OVERPAYMENTS.

(a) General.—Section 1903(d)(2)(C) of the
Social Security Act (42 U.S.C. 1396l(d)(2)(C)) is amended—

(1) in the first sentence, by inserting “or
of 1 year in the case of overpayments due to
fraud” after “60 days”;

(2) in the second sentence, by striking “the
60 days” and inserting “such period”;

(3) by inserting after paragraph (76) the fol-
lowing new paragraph:

“(77) provide that any provider or supplier
(other than a physician or nursing facility)
providing services under such plan shall, sub-
ject to paragraph (5) of section 1875(d), estab-
lish a compliance program described in para-
graph (1) of such section in accordance with
such paragraph.”.

SEC. 1755. MANAGED CARE ORGANIZATIONS.

(a) Minimum Medical Loss Ratio.—

(1) Medicaid.—Section 1939(m)(2)(A) of the
Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as amended by section 1743(a)(3), is amended—

(A) by striking “and” at the end of clause
(xii); and

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

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

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

(2) CHP.—Section 2107(e)(1) of such Act (42 U.S.C. 1396m(e)(2)(A)(vii)) is amended—

(A) by redesignating subparagraphs (H) through (L) as subparagraphs (I) through (M); and

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

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

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

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1902(m)(2)(A)(xii) of the Social Security Act (42 U.S.C. 1396m(m)(2)(A)(xii)) is amended by inserting "and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary" after "patients".

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

SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHIP IF CERTAIN OWNERSHIP, CONTROL, OR MANAGEMENT AFFILIATIONS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after "1128A," the following: "and the participation of any individual or entity in such program if subject to such exceptions are permitted with respect to exclusion under sections 1128(b)(b)(3)(C) and 1128(b)(5), the suspension or exclusion of such individual or entity is terminated under title XVIII, any other State plan under this title, or any child health plan under title XXI.

(b) CHP.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1396ff(e)(1)(A)) is amended by inserting before the period at the end of the following: "and section 1902(a)(39) (relating to exclusion and termination of participation)".

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to claims submitted on or after January 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, and 1753, is further amended—

(1) in paragraph (25); by striking at the end of paragraph (26); and

(2) in paragraph (27), by striking the end of paragraph (26) and inserting "and"; and

(3) by inserting after paragraph (27) the following new paragraph:

"(28) with respect to any amount paid to a billing agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary under section 1396p-2(f)(3)(D),";

(2) in subparagraph (A) of section 1902(a)(39) of such Act (42 U.S.C. 1396a(a)), as amended by section 1751, is amended—

(1) by striking "or" at the end of paragraph (24); and

(2) by striking the period at the end of paragraph (25) and inserting "or"; and

(3) by inserting after paragraph (25) the following new paragraph:

"(29) with respect to any amount paid to a billing agent, clearinghouse, or other alternate payee that is not registered with the State and the Secretary as required under section 1902(a)(39)."

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to claims submitted on or after January 1, 2012, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1760. DENIAL OF PAYMENTS FOR LITIGATION-RELATED MISCONDUCT.

(a) IN GENERAL.—Section 1907(a)(4)(C) of the Social Security Act (42 U.S.C. 1396l(a)(4)(C)), as amended by sections 1751(a) and 1759(b), is amended—

(1) by striking "or" at the end of paragraph (25); and

(2) by striking the period at the end of paragraph (26) and inserting "or"; and

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to claims submitted on or after January 1, 2010.

(1) in clause (ii), by striking "and" at the end of clause (ii); by inserting after "and" the following new clause:

"(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);" and

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

"(4) Not later than September 1, 2010, the Secretary shall do the following:

(A) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title with respect to items or services for which States provide medical assistance under this title and national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(C) Notify States of—

(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(ii) how States are to incorporate such methodologies into claims filed under this title.

(D) Submit a report to Congress that includes notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B)."

Subtitle G—Payments to the Territories

SEC. 1771. PAYMENTS TO TERRITORIES

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1336) is amended—

(1) in subsection (f), by striking "subsection (g)" and inserting "subsections (g) and (h)";

(2) in subsection (g)(1), by striking "With respect to" and inserting "With respect to paragraph (h)," and:

(A) in paragraph (h), by striking "paragraph (g)" and inserting "subsection (g)"; and

(B) in paragraph (h), by adding after "and" the following:

"(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(ii) how States are to incorporate such methodologies into claims filed under this title.

"(D) Submit a report to Congress that includes notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B)."

"(B) in clause (ii), by striking "and" at the end of clause (ii); by inserting after "and" the following new clause:

"(ii) how States are to incorporate such methodologies into claims filed under this title.

Subtitle H—Additional Increase for Fiscal Years 2011 Through 2019—Subject to section 347(b)(1) of the Affordable Health Care for Nevada Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsections (f) and (g) for Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, American Samoa shall be increased by the following amounts:
(4) For Puerto Rico, for fiscal year 2011, $27,500,000; for fiscal year 2012, $37,500,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $23,687,500; for fiscal year 2015, $16,000,000; for fiscal year 2016, $48,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

(5) For Guam, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

(6) For the Northern Mariana Islands, for fiscal year 2011, $13,500,000; fiscal year 2012, $15,000,000; for fiscal year 2013, $15,000,000; for fiscal year 2014, $16,500,000; for fiscal year 2015, $17,500,000; for fiscal year 2016, $18,500,000; for fiscal year 2017, $19,500,000; for fiscal year 2018, $21,000,000; and for fiscal year 2019, $22,000,000.

(7) For American Samoa, fiscal year 2011, $22,000,000; fiscal year 2012, $22,000,000; for fiscal year 2013, $24,877,500; for fiscal year 2014, $24,877,500; for fiscal year 2015, $26,877,500; for fiscal year 2016, $27,877,500; for fiscal year 2017, $29,877,500; for fiscal year 2018, $29,877,500; and for fiscal year 2019, $30,877,500.

(b) REPORT ON ACHIEVING MEDICAID PAYMENTS BEGINNING WITH FISCAL YEAR 2020.—

(1) IN GENERAL.—Not later than October 1, 2013, the Secretary of Health and Human Services shall submit to Congress a report that details a plan for the transition of each territory to full parity in Medicaid with the 50 States and the District of Columbia in fiscal year 2020 by modifying their existing Medicaid programs and outlining actions the Secretary and the governments of each territory must take during fiscal year 2020 to achieve parity in financing. Such report shall include what the Federal medical assistance percentages would be for each territory if the formula used for the 50 States were applied. Such report shall also include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts provided for in section 1108 of the Social Security Act (42 U.S.C. 1396c) should be increased any time before fiscal year 2020 due to any factors that the Secretary deems relevant.

(2) PER CAPITA DATA.—As part of such report the Secretary shall include information about per capita income data that could be used to determine Federal medical assistance percentages under section 1905(b) of the Social Security Act, under section 1108(a)(d)(B) of such Act, for each territory on how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical assistance percentages can be calculated for the territories beginning in fiscal year 2020 to ensure parity with the 50 States.

(2) IN GENERAL.—The Secretary shall submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in achieving the parity in financing outlined in the plan submitted under paragraph (1).

(c) APPLICATION OF FMAP FOR ADDITIONAL FUNDS.—Section 1905(b) of such Act (42 U.S.C. 1396b(a)) is amended by adding at the end the following sentence: ‘’Notwithstanding the first sentence of this subsection and any other provision of law, for fiscal years 2010 through 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of section 5001 of division B of the American Recovery and Reinvestment Act of 2009 (115-5) to such States and the District for calendar quarters during such fiscal years for which such subsections apply.’’.

(d) WAIVERS.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ‘’American Samoa and the Northern Mariana Islands’’ and inserting ‘’Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa’’; and

(B) by striking ‘’American Samoa or the Northern Mariana Islands’’ and inserting ‘’Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa’’.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning with fiscal year 2011.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide nonmonetary technical assistance to the governments of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in upgrading their existing computer systems in order to anticipate and more quickly reimburse necessary to implement the plan contained in the report under subsection (b)(1).

Subtitle H—Miscellaneous

SEC. 1781. TECHNICAL CORRECTIONS.

(a) TECHNICAL CORRECTION TO SECTION 1444 OF THE SOCIAL SECURITY ACT.—The first sentence of section 1444(c)(3) of the Social Security Act (42 U.S.C. 1320b—14(c)(3)) is amended—

(1) by striking ‘’transmitting’’; and

(2) by inserting before the period the following: ‘’as specified in section 1935(a)(4)’’.

(b) ELIMINATION OF FUNDING LIMITATION.—Section 1935(a)(4) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(1) by striking ‘’the maximum amount’’; and

(2) by inserting ‘’the amount’’ in place thereof.

(c) TECHNICAL CORRECTION TO SECTION 1905 OF THE SOCIAL SECURITY ACT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting ‘’or the States and the District’’ after ‘’the States’’.

(d) TECHNICAL CORRECTION TO SECTION 1905 OF THE SOCIAL SECURITY ACT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting ‘’or the States and the District’’ after ‘’the States’’.

SEC. 1782. EXTENSION OF QI PROGRAM.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

(1) by striking ‘’sections 1923 and’’ and by inserting ‘’section’’; and

(2) by striking ‘’December 2010’’ and inserting ‘’December 2014’’.

(b) ELIMINATION OF FUNDING LIMITATION.—

(1) IN GENERAL.—Section 1933 of such Act (42 U.S.C. 1396u–3) is amended—

(A) in subsection (a), by striking ‘’who are selected to receive such assistance under subsection (b)’’;

(B) by striking subsections (b), (c), (e), and (g); and

(C) in subsection (d), by striking ‘’furnished in a State’’ and all that follows and inserting ‘’the Federal medical assistance percentage shall be equal to 100 percent.’’; and

(D) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2011.

SEC. 1783. ASSURING TRANSPARENCY OF INFORMATION.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1753(a), 1759(a), and 1907(b), is amended—

(1) by striking ‘’and’’ at the end of paragraph (79); and

(2) by striking the period at the end of paragraph (80) and inserting ‘’; and’’;

and (3) by striking section 1902(a)(10) the following new paragraph:

‘’(81) provide that the State will establish and maintain laws in accordance with the requirements of section 1921, to require disclosure of information on hospital charges and quality and to make such information available to the public and the Secretary.’’;

and

(4) by inserting after section 1921 the following new section:
‘HOSPITAL PRICE TRANSPARENCY’

‘Sec. 1921A. (a) In General.—The requirements referred to in section 1902(a)(81) are that the laws of a State must—

"(1) require reporting to the State (or its agent) by each hospital located therein, of information on—

(A) the charges for the most common inpatient procedures provided by hospitals for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determinations and the contact information for a specific department of a hospital that responds to such inquiries;

(B) the Medicare and Medicaid reimbursement amount for such services; and

(C) if the hospitals allows for or provides reduced charges for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determinations and the contact information for a specific department of a hospital that responds to such inquiries;

(2) provide for notice to individuals seeking or requiring such services of the availability of information on charges described in paragraph (1);

(3) provide for timely access to such information and allowing the quality of care at each hospital made publicly available in accordance with section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), section 1139A, or section 1139B.

The Secretary shall consult with stakeholders, including state entities in section 1908(d)(6) and the National Governors Association through a formal process to obtain guidance prior to issuing implementing policies under this section.

(b) Hospital Defined.—For purposes of this section, the term ‘hospital’ means an institution that meets the requirements of paragraphs (1) and (7) of section 11361(e) and includes those to which section 1392(c) applies.

(EFFECTIVE DATE: ADMINISTRATION.)

(1) In General.—Except as provided in paragraphs (2)(B) and section 1900, the amendments made by subsection (a) shall take effect on October 1, 2010.

(2) Existing Programs.—

(A) In General.—The Secretary of Health and Human Services shall establish a process by which a State with an existing program may certify to the Secretary that its program satisfies the requirements of section 1921A of the Social Security Act, as inserted by subsection (a).

(B) 2-YEAR PERIOD TO BECOME IN COMPLIANCE.—States that, as of the date of the enactment of this Act, administer hospital price transparency policies that do not meet such requirements shall have 2 years from such date to take necessary modifications to come into compliance and shall not be considered in full compliance with such requirements during such 2-year period.

SEC. 1784. MEDICAID AND CHIP PAYMENT AND HEARING COMMISSION

(a) Reporting on Nursing Facility Payment Policies.—Section 1900(b) of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new paragraph:

"(d) Reports on Special Topics on Payment Policies.—

"(A) Nursing Facility Payment Policies.—Not later than January 1, 2012, the Commission shall submit to Congress a report on nursing facility payment policies under Medicaid and CHIP that includes—

"(i) information on the difference between the amount paid by each State to nursing facilities in such State under the Medicaid program and the amount that the State would pay if such facilities of providing efficient quality care to Medicaid eligible individuals;"
determine whether or not the patient has been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. State plan amendments to the demonstration project may manage the provision of these benefits under the project through utilization review, authorization, or management of care program to evaluate the medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) ELIGIBILITY.—To be eligible for funds under this section, a State shall meet the following:

(A) Be an eligible State, as defined in section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(n)).

(B) Have submitted an application for a demonstration project under this section.

(2) STATE DESCRIBED.—States shall be selected by the Secretary in a manner so as to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

(d) LENGTH OF DEMONSTRATION PROJECT.—

The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2010.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2012.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2012.

(4) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allotment under paragraph (2), an amount equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance for individuals eligible for assistance under title XIX of the Social Security Act (42 U.S.C. 1396a(e)(10)(A) (relating to comparability) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ‘‘emergency medical condition’’ means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ‘‘Federal medical assistance percentage’’ means the percentage obtained by dividing the amount determined under paragraph (1) or (2) of section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(n)) by the total amount of Federal medical assistance payments made under title XIX of the Social Security Act (42 U.S.C. 1396a).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ‘‘institution for mental diseases’’ has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ‘‘medical assistance’’ has the meaning given to that term in section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a).

(5) STABILIZED.—The term ‘‘stabilized’’ means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term ‘‘State’’ has the meaning given to that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 1788. APPLICATION OF MEDICAID IMPROVEMENT FUND.

Section 1911(b)(1) of the Social Security Act (42 U.S.C. 1396w-1(b)(1)) is amended by striking all that follows and inserting ‘‘From the Fund, only such amounts as may be appropriated (or otherwise made available by law).’’. 

SEC. 1790. RULE FOR CHANGES REQUIRING STATE LEGISLATION.

In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services finds that the broker has established and maintains procedures to ensure the independence of its enrollment activities from the interests of any managed care entity or provider; and

(2) subparagraph (B) is amended by striking ‘‘(ii)’’ after ‘‘other’’. 

TITLe VIII—REVENUE-RELATED PROVISIONS

SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION’S OUTREACH TO ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Paragraph (19) of section 6103(l) of the Internal Revenue Code of 1986 is amended to read as follows:

“(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION’S OUTREACH TO ELIGIBLE INDIVIDUALS.—

“(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the Social Security Administration, with respect to any taxpayer identified by the Commissioner of Social Security—

(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year from returns with respect to wages (as defined in section 3212(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

(iii) the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from wages and income from self-employment, on such return,

(iv) if the individual is a married individual filing a separate return for the applicable year, the income tax return (if reasonably available) of the spouse on such return,
"(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, self-insured plans for such fiscal year, as determined by the Internal Revenue Service's taxpayer information records.

"(vi) such other return information relating to the individual (or the individual’s spouse on such return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act.

"(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term ‘applicable year’ means each fiscal year beginning with fiscal year 2013, for which information is available in the Internal Revenue Service’s taxpayer information records.

"(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

"(1) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act and who have not applied for such subsidy, and

"(2) the Social Security Administration has identified as a spouse of an individual described in clause (1).

"(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals who may be eligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act for use in outreach efforts under section 1144 of chapter 34 of the Act.

"(E) SAFEGUARDS.—Paragraph (4) of section 6103(b) of such Code is amended—

"(1) by striking ‘(19),’ each place it appears, and

"(2) by striking ‘or (17)’ each place it appears and inserting ‘(17), or (19).’

"(F) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking ‘(19),’

"(G) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of enactment of this Act.

SEC. 1802. CREATION OF TRUST FUND; FINANCING OF TRUST FUND.

(a) ESTABLISHMENT OF TRUST FUND.—

"(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"Sec. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There shall be a trust fund to be known as the ‘Health Care Comparative Effectiveness Research Trust Fund’ (hereinafter in this section referred to as the ‘CERTF’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—

"(1) IN GENERAL.—There are hereby appropriated to the Trust Fund the following:

"(A) For fiscal year 2010, $70,000,000.

"(B) For fiscal year 2011, $90,000,000.

"(C) For fiscal year 2012, $110,000,000.

"(D) For each fiscal year beginning with fiscal year 2013, the amount determined under subsection (c)(1) for such fiscal year.

"(2) ALLOCATION FOR COMMISSION.—

"(A) IN GENERAL.—For each fiscal year beginning with fiscal year 2013, the Secretary of Health and Human Services shall allocate from the CERTF and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are attributable to the effects of part B of title XVIII of such Act from the respective trust fund or account.

"(B) APPROPRIATIONS NOT SUBJECT TO FISCAL YEAR LIMITATIONS.—Paragraphs (1) and (2) of section 9511 shall apply to the amounts appropriated by paragraph (1) of this section and subchapter B of chapter 34 of such Act.

"(C) PERIODIC TRANSFERS, ESTIMATES, AND ADJUSTMENTS.—As provided in subpart A of part IV of subchapter D of chapter 34 of such Act, the provisions of section 9601 shall apply to the amounts appropriated by paragraph (1) of this section.

"(D) NET REVENUES.—For purposes of this section:

"(i) the fees received in the Treasury under subchapter B of chapter 34, over the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

"(ii) the decrease in the tax imposed by such subchapter.

"(ii) any individual the Social Security Administration has identified as a spouse of such individual (or the individual’s spouse on such return, and

"(iii) such other return information relating to the individual (or the individual’s spouse on such return), as determined by the Internal Revenue Service’s taxpayer information records.

"(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term ‘applicable year’ means each fiscal year beginning with fiscal year 2013, for which information is available in the Internal Revenue Service’s taxpayer information records.

"(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

"(1) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act and who have not applied for such subsidy, and

"(2) the Social Security Administration has identified as a spouse of an individual described in clause (1).

"(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals who may be eligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act for use in outreach efforts under section 1144 of chapter 34 of the Act.

"(E) SAFEGUARDS.—Paragraph (4) of section 6103(b) of such Code is amended—

"(1) by striking ‘(19),’ each place it appears, and

"(2) by striking ‘or (17)’ each place it appears and inserting ‘(17), or (19).’

"(F) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking ‘(19),’

"(G) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of enactment of this Act.

"Sec. 4375. Health insurance.

"Sec. 4376. Self-insured health plans.

"Sec. 4377. Definitions and special rules.

"Sec. 4376. Health insurance.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"Sec. 4376. Self-insured health plans.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"Sec. 4375. Health insurance.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"Sec. 4376. Self-insured health plans.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.
“(A) the employer in the case of a plan established or maintained by a single employer, (B) the employee organization in the case of a plan established or maintained by an employee organization, (C) in the case of—

(i) a plan established or maintained by 2 or more employers and 1 or more employee organizations, (ii) a multiple employer welfare arrangement, or (iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

(C) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

(i) any portion of such coverage is provided other than through an insurance policy, and

(ii) such plan is established or maintained by—

(A) one or more employers for the benefit of their employees or former employees, (B) one or more employee organizations for the benefit of their members or former members, (C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees, (D) by a voluntary employees’ beneficiary association described in section 501(c)(9), (E) by any organization described in section 501(c)(6), or

(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

SEC. 4377. DEFINITIONS AND SPECIAL RULES.

(a) Definitions.—For purposes of this subchapter—

(1) ACCIDENT AND HEALTH COVERAGE.—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy or plan would cause such policy to be a specified health insurance policy (as defined in section 4980B(c)).

(2) INSURANCE POLICY.—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

(3) UNITED STATES.—The term ‘United States’ includes any possession of the United States.

(b) Treatment of Governmental Entities—

(1) IN GENERAL.—For purposes of this subchapter—

(A) the term ‘person’ includes any governmental entity, and

(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

(2) EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4376 or section 4376A on any covered health plan under such program.

(c) Exempt Governmental Program Defined.—For purposes of this subchapter, the term ‘exempt governmental program’ means—

“(A) any insurance program established under title XVIII of the Social Security Act, (B) the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are reused as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.


SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5070 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008” after “December 31, 2009.”

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting “and for fiscal year 2010” after “$6,000,000.”

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking “2010” and inserting “2010 or until expended”.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking “December 1, 2008” and inserting “March 31, 2011.”

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking “May 1, 2010” and inserting “September 30, 2011.”

SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

Part B of title IV of the Social Security Act (42 U.S.C. 621–629) is amended by adding at the end the following:

“Subpart 3—Support for Quality Home Visitation Programs

SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, and such Applications and such Submissions, the Secretary may require, an application for the grant that includes the following:

(1) TheDescription of the Demonstration Programs.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

(B) the number and types of families who are receiving services under the programs;

(C) the sources and amount of funding provided to the programs;

(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services;

(E) training and technical assistance activities designed to achieve or support the goals of the programs.

(3) ASSURANCES.—Assurances from the State that

(A) in supporting home visitation programs using funds provided under this section, the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

(B) the State will reserve 5 percent of the grant funds for training and technical assistance to the home visitation programs using such funds;

(C) in supporting home visitation programs using funds provided under this section, the State will promote coordination and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

(D) home visitation programs supported using such funds will, when appropriate, provide coordination and collaboration with other programs serving children and families; and

(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

(4) OTHER INFORMATION.—Such other information as the Secretary may require.
(c) ALLOCATIONS.—

(1) INDIAN TRIBES.—From the amount re-

served under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian

tribe whose families have income that does not exceed 200 percent of the poverty line

bears to the total number of children in such Indian tribes whose families have income that
does not exceed 200 percent of the poverty line.

(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not a tribe whose families have income that does not exceed 200 percent of the poverty line.

(3) REALLOTTMENTS.—The amount of any allotment under paragraph (1) of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section and not used for reallocation under the allotment methodology specified in that paragraph. Any amount so reallocated to a State is deemed part of the allotment of the State under paragraph (1).

(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this paragraph, for a fiscal year if the Secretary finds that the amount that the State expends by the State pursuant to this section for home visitation with the strongest evidence of effectiveness does not exceed 200 percent of the poverty line.

(e) PAYMENT OF GRANT.—

(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under subsection (m) in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term ‘reimbursable percentage’ means, with respect to a fiscal year—

(A) 85 percent, in the case of fiscal year 2010;
(B) 80 percent, in the case of fiscal year 2011;
(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year;

(f) ELIGIBLE EXPENDITURES.—

(1) IN GENERAL.—In this section, the term ‘eligible expenditures’—

(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined outcomes, including reducing abuse and neglect and improving child health and development;

(ii) employ well-trained and competent staff, maintain high quality supervision, provide for ongoing training and professional development, and show strong organizational capacity for data collection and evaluation; and

(iii) establish appropriate linkages and referrals to other community resources and supports; and

(iv) maintain fidelity of program implementation to ensure that services are delivered according to the specified model, and

(v) provide parents with—

(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);

(II) knowledge of realistic expectations of age-appropriate child behaviors;

(III) knowledge of wellness issues for children and parents;

(IV) modeling, consulting, and coaching on parenting practices;

(V) skills to interact with their child to enhance age-appropriate development;

(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

(VII) activities designed to help parents become full partners in the education of their children;

(B) includes expenditures for training, technical assistance, and evaluations related to the programs and

(C) does not include any expenditure with respect to which the Secretary has made a claim for payment under any other provision of Federal law.

(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that are designed to a model of home visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term ‘applicable percentage’ means, with respect to a fiscal year—

(1) 60 percent for fiscal year 2010;

(2) 55 percent for fiscal year 2011;

(3) 50 percent for fiscal year 2012;

(4) 45 percent for fiscal year 2013; or

(5) 40 percent for fiscal year 2014.

(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

(A) the Secretary waives the requirement; or

(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

(j) EVALUATION.—

(1) IN GENERAL.—The Secretary shall, by grant contract, procurement, or a conduct of an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

(A) The effect of home visitation programs on child and parent outcomes, including indicator of which the ability of programs to improve outcomes varies across programs

(2) REPORTS TO THE CONGRESS.—

(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

(k) ANNUAL REPORTS TO THE CONGRESS.—

The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

(1) The high need communities targeted by States for programs carried out under this section.

(2) The characteristics of the programs, including—

(A) the qualifications and demographic characteristics of program staff; and

(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

(3) The outcomes reported by the programs.

(4) The research-based instruction, materials, and activities being used in the activities funded under the grant.

(5) The training and technical assistance activities, including on-going professional development, provided to the programs.
"(7) The annual costs of implementing the programs, including the cost per family served under the programs.

"(8) The indicators and methods used by States to determine whether the programs are being implemented as designed.

"(1) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (b), the Secretary shall reserve—

"(1) $50,000,000 for fiscal year 2010;

"(2) $100,000,000 for fiscal year 2011;

"(3) $150,000,000 for fiscal year 2012;

"(4) $200,000,000 for fiscal year 2013; and

"(5) $250,000,000 for fiscal year 2014.

"(2) RESERVATIONS OF FUNDS.—From the amounts appropriated under section 1907(a)(2), the Secretary shall reserve—

"(1) $50,000,000 for fiscal year 2010;

"(2) $100,000,000 for fiscal year 2011;

"(3) $150,000,000 for fiscal year 2012;

"(4) $200,000,000 for fiscal year 2013; and

"(5) $250,000,000 for fiscal year 2014.

"(3) The programs established under paragraphs (1) and (2) shall be construed as statutes.

"(4) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7), under Medicaid, and in the low-income subsidy program under section 1807(b), to identify methods to more efficiently and effectively reach and enroll dual eligibles.

"(5) An assessment of communication strategies used to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1-800-MEDICARE, and the Medicare Advantage call centers.

"(6) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and lead to better coordination of community-based care.

"(7) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

"(8) Support for coordination of State and Federal contracting and oversight for dual coordination programs of the goals described in subsection (b).

"(9) Support for agencies and entities through the provision of technical assistance for Medicare and Medicaid coordination initiatives designed to improve acute and long-term care coordination for dual eligibles.

"(10) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

"(11) Coordination of activities relating to Medicare and Medicaid plans under 1806(b)(3) of title XVIII.

"(12) R EPORT.—Not later than January 1, 2011, the Secretary shall—

"(A) include the assessment of current and future cost-intensive conditions described in subsection (g); and

"(B) submit a report described in subsection (a)(2) to the Committees specified in subsection (a)(2) on such updated assessment and recommendations.

"(2) The Secretary shall provide to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions of the Senate on the assessment conducted under paragraph (1). Such report shall—

"(A) include the assessment of current and future cost-intensive conditions described in such paragraph; and

"(B) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified; and

"(C) include recommendations concerning research in the Departments of Health and Human Services and in agencies that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

"(3) In accordance with section 910(b) of title XX, the Committees shall—

"(A) at a hearing on the first report submitted under this subsection, seek endorsement by the entity with a contract under section 1809(a) of quality measures and benchmarks developed under this section; and

"(B) RECEIVE REPORT.—Not later than January 1, 2013, and biennially thereafter, the Committees shall—

"(1) review and update the assessment and recommendations described in subsection (a)(1); and

"(2) submit a report described in subsection (a)(2) to the Committees specified in subsection (a)(2) on such updated assessment and recommendations.

"(b) E LEMENTS.—The following shall be elements of the scorecard:

"(1) Identify areas of such policies where better coordination and protection could be improved and lead to better coordination of community-based care.

"(2) Identify areas of such policies where better coordination and protection could be improved and lead to better coordination of community-based care.

"(3) Issue guidance to States regarding improving such coordination and protection.

"(4) The scorecard shall include the assessment of current and future cost-intensive conditions described in subsection (g).

"(5) The Secretary shall provide to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions of the Senate on the assessment conducted under paragraph (1). Such report shall—

"(A) include the assessment of current and future cost-intensive conditions described in subsection (g); and

"(B) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified; and

"(C) include recommendations concerning research in the Departments of Health and Human Services and in agencies that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

"The Secretary shall—

"(1) in general .—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to applicable individuals described in paragraph (4)(A).

"(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

"(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult with representatives of relevant Federal agencies, clinical and analytical experts with expertise in medicine and health care management, and States. The CMI shall use open forums or other mechanisms to seek input from interested parties.

"(4) DEFINITIONS.—In this section:

"(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who has been determined to be dual eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

"(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.

"(3) SEC. 1907. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION.

"SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

"(1) In general .—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to applicable individuals described in paragraph (4)(A).

"(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

"(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult with representatives of relevant Federal agencies, clinical and analytical experts with expertise in medicine and health care management, and States. The CMI shall use open forums or other mechanisms to seek input from interested parties.

"(4) DEFINITIONS.—In this section:

"(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who has been determined to be dual eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

"(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.

"(3) SEC. 1908. ASSESSMENT OF MEDICARE COST-IN-ТЕNSIVE DISEASES AND CONDITIONS.

"(a) INITIAL ASSESSMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program and, to the extent possible, assess the cost-intensive for Medicare in the future. In conducting the assessment, the Secretary shall include the National Institutes of Health, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

"(b) R EPORT.—Not later than January 1, 2011, the Secretary shall transmit a report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions of the Senate on the assessment conducted under paragraph (1). Such report shall—

"(A) include the assessment of current and future cost-intensive conditions so identified; and

"(B) include recommendations concerning research in the Departments of Health and Human Services and in agencies that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

"(c) METHODS FOR ASSESSMENT.—

"(1) IDENTIFICATION OF DISEASES AND CONDITIONS.—

"(A) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.

"(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.

"(3) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.

"(4) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.
(A) APPLICABLE INDIVIDUAL.—The term ‘applicable individual’ means—

(i) an individual who is enrolled under part B and entitled to benefits under part A of title XVIII;

(ii) an individual who is eligible for medical assistance under title X; or

(iii) an individual who meets the criteria of both clauses (i) and (ii).

(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVIII, title XIX, or both.

(3) TESTING OF MODELS (PHASE I).—

(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

(2) SELECTION OF MODELS TO BE TESTED.—

(A) IN GENERAL.—The Secretary shall give preference to testing models for which, as determined by the Administrator of the Centers for Medicare & Medicaid Services and using criteria established outside the Centers as the Administrator determines appropriate, there is evidence that the model addresses a problem of national significance, and expansions.

(B) APPLICATION TO OTHER DEMONSTRATION PROGRAMS.—The CMI shall test payment and service delivery models described in subsection (b) and identified in the Secretary’s report under section (c) including the determination that a model is not expected to meet criteria described in paragraphs (1) or (2) of such subsection.

(4) FUNDING FOR TESTING ITEMS AND SERVICES.—

(A) ADDITIONAL BENEFITS.—There shall be available, in addition to amounts appropriated under this section (b), $350,000,000 for fiscal year 2010, $440,000,000 for fiscal year 2011, $550,000,000 for fiscal year 2012, and not less than $400,000,000 for each fiscal year beginning with fiscal year 2013, for the payment of the costs of payment models tested under this subsection.

(B) MEDICAID CONFORMING AMENDMENT.—

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), and 1759(a), is amended—

(1) in paragraph (78), by striking “and” at the end; and

(2) in paragraph (79), by striking the period at the end and inserting “; and”;

(3) by inserting after paragraph (79) the following new paragraph:

“(80) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.”.

SEC. 1908. APPLICATION OF EMERGENCY SERVICES LAWS.

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

SEC. 1909. DISREGARD UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM FOR COMPANION PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.

(a) IN GENERAL.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(1) by striking “and” at the end of paragraph (2); and

(2) by striking the period at the end of paragraph (25) and inserting “; and”;

(3) by adding at the end the following:

“(26) The first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial to test a treatment for a rare disease or condition (within the meaning of section 240 of the Orphan Drug Act (Public Law 97–414)), that—

(A) has been reviewed and approved by an institutional review board that has been established to protect the rights and welfare of human subjects participating in research; and

(B) meets the standards for such bodies set forth in section 46 of title 45, Code of Federal Regulations; and

(B) meets the standards for protection of human subjects for clinical research (as set forth in such part 46); and

(b) RESOURCES DISREGARD.—Section 1613(a) of such Act (42 U.S.C. 1382b(a)) is amended—

(1) by striking “and” at the end of paragraph (5); and

(2) by striking the period at the end of paragraph (16) and inserting “; and”; and

Program Management Account $25,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this sub-paragraph for a fiscal year shall be available until expended.

“(e) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the payment models tested under subsection (b), including the numbers described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments for services under such models on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary believes are appropriate for legislative action to facilitate the development and expansion of successful payment models.”.
(3) by inserting after paragraph (16) the following:

“(17) the first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial, as described in section 1612(b)(26)).”;

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for calendar months beginning after the earlier of—

(1) the date the Commissioner of Social Security promulgates regulations to carry out the amendments; or

(2) the 180-day period that begins with the date of the enactment of this Act.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

(a) TABLE OF CONTENTS.—The table of contents of this division is as follows:

Sec. 2001. Table of contents; references.

TITILE I—COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding.

TITILE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

Sec. 2201. National Health Service Corps.
Sec. 2202. Authorizations of appropriations.

PART 2—PROMOTION OF PRIMARY CARE AND DIVERSITY

Sec. 2211. Frontline health providers.

”SUBPART XI—HEALTH PROFESSIONAL NEEDS AREAS

”Sec. 340I. In general.
”Sec. 340J. Loan repayments.
”Sec. 340K. Allocation.

Sec. 2212. Primary care student loan funds.
Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistants.
Sec. 2214. Training of medical residents in community-based settings.
Sec. 2215. Training for general, pediatric, and public health dentists and dental hygienists.
Sec. 2216. Authorization of appropriations.
Sec. 2217. Study on effectiveness of scholarships and loan repayments.

Subtitle B—Nursing Workforce

Sec. 2221. Amendments to Public Health Service Act.

Subtitle C—Public Health Workforce

Sec. 2231. Public Health Workforce Corps.

”SUBPART XII—PUBLIC HEALTH WORKFORCE

”Sec. 340L. Public Health Workforce Corps.
”Sec. 340M. Public Health Workforce Scholarship Program.
”Sec. 340N. Public Health Workforce Loan Repayment Program.

Sec. 2232. Enhancing the public health workforce.
Sec. 2233. Public health training centers.
Sec. 2234. Preventive medicine and public health training grant program.
Sec. 2235. Authorization of appropriation.

Subtitle D—Adapting Workforce to Evolving Health System Needs

PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds.
Sec. 2242. Nursing workforce diversity grants.
Sec. 2243. Coordination of diversity and cultural competency programs.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

Sec. 2251. Cultural and linguistic competency training for health professionals.
Sec. 2252. Innovations in interdisciplinary care training.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

Sec. 2261. Health workforce evaluation and assessment.

PART 4—HEALTH WORKFORCE ASSESSMENT

Sec. 2271. Health workforce assessment.

PART 5—AUTHORIZATION OF APPROPRIATIONS

Sec. 2281. Authorization of appropriations.

TITLE III—PREVENTION AND WELLNESS

Sec. 2301. Prevention and wellness.

”TITLE XXXI—PREVENTION AND WELLNESS

”Subtitle A—Prevention and Wellness Trust

Sec. 3101. Prevention and wellness trust fund.
Sec. 3102. Use of trust fund.
Sec. 3103. Trust fund administrative expenses.

Sec. 3111. Prevention and Wellness Trust.

”Subtitle B—National Prevention and Wellness Strategy


”Subtitle C—Prevention Task Forces

Sec. 3131. Task Force on Community Preventive Services.
Sec. 3132. Task Force on Community Preventive Services.

”Subtitle D—Prevention and Wellness Research

Sec. 3141. Prevention and wellness research activity coordination.
Sec. 3142. Community prevention and wellness research grants.
Sec. 3143. Research on subsidies and rewards to encourage wellness and healthy behaviors.

”Subtitle E—Delivery of Community Prevention and Wellness Services

Sec. 3151. Community prevention and wellness services grants.

”Subtitle F—Core Public Health Infrastructure

Sec. 3161. Core public health infrastructure for State, local, and tribal health departments.
Sec. 3162. Core public health infrastructure and activities for CDC.

”Subtitle G—General Provisions

Sec. 3171. Definitions.

TITILE IV—QUALITY AND SURVEILLANCE

Sec. 2402. Assistant Secretary for Health Information.
Sec. 2403. Authorization of appropriations.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

Sec. 2501. Expanded participation in 340B program.
Sec. 2502. Improvements to 340B program integrity.
Sec. 2503. Effective date.

Subtitle B—Programs

PART 1—GRANTS FOR CLINICS AND CENTERS

Sec. 2511. School-based health clinics.
Sec. 2512. Nurse-Managed health centers.
Sec. 2513. Federally qualified behavioral health centers.

PART 2—OTHER GRANT PROGRAMS

Sec. 2521. Comprehensive programs to provide education to nurses and create a pipeline to nursing.

Sec. 2522. Mental and behavioral health training.
Sec. 2523. Reauthorization of telehealth and telemedicine grant programs.
Sec. 2524. No child left unvaccinated against influenza: demonstration program using elementary and secondary schools as influenza vaccination centers.
Sec. 2525. Extension of Wisewoman Program.
Sec. 2526. Healthy teen initiative to prevent teen pregnancy.
Sec. 2527. National training initiatives on autism spectrum disorders.
Sec. 2528. Implementation of medication management services in treatment of chronic diseases.
Sec. 2529. Postpartum depression.
Sec. 2530. Grants to promote positive health behaviors and economic outcomes.
Sec. 2531. Medical liability alternatives.
Sec. 2532. Infant mortality pilot programs.
Sec. 2533. Secondary school health sciences training program.
Sec. 2534. Community-based collaborative care networks.
Sec. 2535. Community-based overweight and obesity prevention program.
Sec. 2536. Reducing student-to-school nurse ratios.
Sec. 2537. Medical-legal partnerships.
Sec. 2538. Screening, Brief Intervention, referral, and treatment for mental health and substance abuse disorders.
Sec. 2539. Grants to assist in developing medical schools in federally-designated health professional shortage areas.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

Sec. 2551. Trauma care centers.
Sec. 2552. Emergency care coordination.
Sec. 2553. Pilot programs to improve emergency medical care.
Sec. 2554. Assisting veterans with military emergency medical training to become State-licensed or certified emergency medical technicians (EMTs).
Sec. 2555. Dental emergency responders: public health and medical response.
Sec. 2556. Dental emergency responders: homeland security.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

Sec. 2561. Institute of Medicine Conference on Pain.
Sec. 2562. Pain research at National Institutes of Health.
Sec. 2563. Public awareness campaign on pain management.

Subtitle C—Food and Drug Administration

Sec. 2571. National medical device registry.
Sec. 2572. Nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines.
Sec. 2573. Protecting consumer access to generic drugs.

PART 2—BIOLOGICALS

Sec. 2574. Licensure pathway for biosimilar biological products.
Sec. 2575. Fees relating to biosimilar biological products.
Sec. 2576. Amendments to certain patent provisions.

Subtitle D—Community Living Assistance Services and Supports

Sec. 2581. Establishment of national voluntary insurance program for purchase of noninstitutional long-term care services and support (CLASS program).
TITLE XXXI—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

Sec. 3201. Purpose.

Sec. 3202. Definitions.

Sec. 3203. CLASS Independence Benefit Expansion Plan

Sec. 3204. Enrollment and disenrollment requirements.

Sec. 3205. Benefits.

Sec. 3206. CLASS Independence Fund.

Sec. 3207. CLASS Independence Advisory Council.

Sec. 3208. Regulations; annual report.

Sec. 3209. Inspector General's report.

SUBTITLE E—Miscellaneous

Sec. 2585. States failing to adhere to certain employment obligations.

Sec. 2586. Health centers under Public Health Service Act; liability protections for volunteer practitioners.

Sec. 2587. Report to Congress on the current state of health centers that have been overlooked among the poorest Americans.

Sec. 2588. Office of Women's Health.

Sec. 2589. Long-Term Care and Family Caregiver Support.

Sec. 2590. Web site on health care labor market statistics (including funds appropriated under the authority of sections 736, 740, 741, and 747 of such Act (42 U.S.C. 293, 293d, and 293d-i)).

Sec. 2591. Online health workforce training programs.

Sec. 2592. Access for individuals with disabilities.

Sec. 2593. Duplicative Grant programs.

Sec. 2594. Diabetes screening collaboration program.

Sec. 2595. Improvement of vital statistics collection.

Sec. 2596. National health service corps demonstration on incentive payments.

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to or the insertion of another provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2597. NATIONAL HEALTH SERVICE CORPS.

SEC. 2598. NATIONAL HEALTH SERVICE CORPS DEMONSTRATION PROGRAM.

(a) In general.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (2)) for a fiscal year only if (excluding any amounts appropriated from other funds in the Fund) the amounts specified in subparagraph (B) for the fiscal year involved are equal to or greater than the amounts specified in subparagraph (A) for the fiscal year involved.

(b) Amounts specified.—The amounts specified in this subparagraph, with respect to a fiscal year are the amounts (excluding any amounts appropriated from other funds in the Fund) for the following:

(i) Community health centers (including funds appropriated under the authority of section 338 of the Public Health Service Act (42 U.S.C. 254k)).

(ii) The National Health Service Corps Program (including funds appropriated under the authority of section 338 of such Act (42 U.S.C. 254k)).

(iii) The National Health Service Corps Scholarship and Loan Repayment Programs (including funds appropriated under the authority of section 338h of such Act (42 U.S.C. 254h)).

(iv) Primary care education programs (including funds appropriated under the authority of sections 736, 740, 741, and 747 of such Act (42 U.S.C. 293, 293d, and 293d-i)).

(v) Sections 761 and 770 of such Act (42 U.S.C. 294n and 294n-1).

(vi) Nursing workforce development (including funds appropriated under the authority of title IX of such Act (42 U.S.C. 299 et seq.)).

(vii) The National Center for Health Statistics (including funds appropriated under the authority of sections 394, 398, 397, and 388 of such Act (42 U.S.C. 242d, 242k, 242l, and 242m)).

(viii) The Agency for Healthcare Research and Quality (including funds made available under the authority of title IX of such Act (42 U.S.C. 299 et seq.)).

SEC. 2599. DEFICIT NEUTRALITY.

(a) Availability.—Funds appropriated or made available pursuant to sections 330(a), 338(c), 338h-1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division, are only available for the purposes set forth in this division and shall not be available and are precluded from obligation for any other purpose.

(b) Estimating budgetary impact.—For the purposes of estimating the spending effects of this Act, the authorization of appropriations from the Fund, to the extent amounts derived from the general revenues of the Treasury shall be treated as new direct spending and attributed to this Act.

(c) Treatment.—For the purposes of section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, the Fund, to the extent amounts in the Fund are derived from the general revenues of the Treasury, and not in excess of amounts subsequently appropriated from the Fund, shall be deemed to be included on the list of appropriations referenced under section 256(b)(17) of that Act.

TITLE I—COMMUNITY HEALTH CENTER S

SEC. 2601. INCREASED FUNDING.

Section 330 of the Public Health Service Act (42 U.S.C. 254c) is amended—

(1) IN GENERAL.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (2)) for a fiscal year only if (excluding any amounts appropriated from other funds in the Fund) the amounts specified in subparagraph (B) for the fiscal year involved are equal to or greater than the amounts specified in subparagraph (A) for the fiscal year involved.

(2) BASELINE FUNDING.—(A) IN GENERAL.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (1)) for each of fiscal years 2013 through 2015.

(b) ADDITIONAL FUNDING.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated out of any amounts in the Public Health Investment Fund, the following:

(i) For fiscal year 2011, $1,000,000,000.

(ii) For fiscal year 2012, $1,000,000,000.

(iii) For fiscal year 2013, $500,000,000.

(iv) For fiscal year 2014, $3,000,000,000.

(v) For fiscal year 2015, $4,000,000,000.

T I T L E II—W A I V E R S

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

SEC. 2201. NATIONAL HEALTH SERVICE CORPS.

(a) Fulfillment of obligated service requirement through half-time service—

(1) Waivers.—Subsection (i) of section 331 (42 U.S.C. 254d) is amended—

(A) in paragraph (1), by striking "in carrying out subpart III" and all that follows through the period and inserting "in carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship and Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half-time;"

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking "less than full time" each place it appears and inserting "half time";

(ii) in subparagraphs (C) and (F), by striking "less than full-time service" each place it appears and inserting "half-time service";

and

(iii) by amending subparagraphs (D) and (E) to read as follows:

"(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;"

"(E) the Corps member agrees in writing to fulfill all of the service obligations under section 333 through half-time clinical practice and either—"

"(i) double the period of obligated service that would otherwise be required; or"

"(ii) in the case of a Corps member enrolled into under section 338h, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and"

"(C) in paragraph (3), by striking "in evaluating a demonstration project described in paragraph (1)" and inserting "in evaluating waivers issued under paragraph (1)";

(2) Definitions.—Subsection (j) of section 331 (42 U.S.C. 254d) is amended by adding at the end the following:

"(b) Loan repayment amount.—Section 333 (42 U.S.C. 254d) is amended by striking "$35,000" and inserting "$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation;"

and

"(d) Treatment of as obligated service.—Subsection (a) of section 338c (42 U.S.C. 254c) is amended—"
U.S.C. 254m) is amended by adding at the end the following: “The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.”

SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.
(a) National Health Service Corps Program.—Section 338 (42 U.S.C. 254k) is amended—
(1) in subsection (a), by striking “2012” and inserting “2015”; and
(2) by adding at the end the following:

“(c) To the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated among the public Health Investment Fund, the following:

“(1) $65,000,000,000 for fiscal year 2011.
“(2) $66,000,000,000 for fiscal year 2012.
“(3) $70,000,000,000 for fiscal year 2013.
“(4) $73,000,000,000 for fiscal year 2014.
“(5) $77,000,000,000 for fiscal year 2015.

(b) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254f et seq.) is amended—
(1) in section 336H(a)—
(A) in paragraph (4), by striking “and” at the end; and
(B) in paragraph (5), by striking the period at the end and inserting “;” and;
(2) by adding at the end the following:

“(6) for each of fiscal years 2013 through 2015, such sums as may be necessary.”; and
(3) by inserting after section 336H the following:

SEC. 338H–1. ADDITIONAL FUNDING.
“For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

“(1) $354,000,000,000 for fiscal year 2011.
“(2) $366,000,000,000 for fiscal year 2012.
“(3) $378,000,000,000 for fiscal year 2013.
“(4) $392,000,000,000 for fiscal year 2014.
“(5) $396,000,000,000 for fiscal year 2015.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

SEC. 2211. FRONTLINE HEALTH PROVIDERS.
Part D of title III (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

“Subpart XI—Health Professional Needs Areas

SEC. 340H. IN GENERAL.
“(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program, to be known as the Frontline Health Providers Loan Repayment Program, to address unmet health care needs in health professional needs areas through loan repayments under section 340I.

“(b) DESIGNATION OF HEALTH PROFESSIONAL NEEDS AREAS.—
“(1) In general.—In this subpart, the term ‘health professional needs area’ means an area, population, or facility that is designated by the Secretary in accordance with paragraph (2).

“(2) DISQUALIFICATION.—To be designated by the Secretary as a health professional needs area under this subpart:

“(A) In the case of an area, the area must be a rational area for the delivery of health services.

“(B) The area, population, or facility must have, or be expected to have, more health disciplines, specialties, or subspecialties for the population served, as determined by the Secretary—

“(i) insufficient capacity of health professionals; or

“(ii) high needs for health services, including services to address health disparities.

“(C) With respect to the delivery of primary health services, the area, population, or facility must not include a health professional shortage area (as designated under section 338B), or an underserved area, population, or facility, or facility may include such a health professional shortage area in which there is an unmet need for such services.

“(d) ELIGIBLE INDIVIDUALS.—An individual eligible to participate in the Program, an individual shall—

“(1) hold a degree in a course of study or program (approved by the Secretary) from a school of public health, that is designated by the Secretary, or a school defined in paragraph (1)(A) (other than a school of public health);

“(2) hold a degree in a course of study or program (approved by the Secretary) from a school defined in subparagraph (C), (D), or (E) of section 799H(1), as designated by the Secretary;

“(3) be enrolled as a full-time student—

“(A) in a school or program defined in subparagraph (C), (D), or (E) of section 799H(1), as designated by the Secretary, or a school described in paragraph (1); and

“(B) in the final year of a course of study or program, offered by such school or program and approved by the Secretary, leading to a degree in a discipline referred to in subparagraph (D) (as defined by the Secretary) in a health discipline, or a specialty, or subspecialty for the population

“(4) be a practitioner described in section 186b(k)(1)(B) (42 U.S.C. 254m) is amended by adding at the end the following:

“(5) be a practitioner in the field of respiratory therapy, medical technology, or radiologic technology.

“(d) DEFINITIONS.—In this subpart:

“(1) The term ‘health disparities’ has the meaning given to such term in section 3171.

“(2) The term ‘primary health services’ has the meaning given to such term in section 331(a)(3)(D).

SEC. 340I. LOAN REPAYMENTS.
“(a) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall enter into contracts with individuals under which:

“(1) the individual agrees—

“(A) to serve as a full-time primary health services provider or as a full-time part-time provider of primary health services for a period of time equal to 2 years or such longer period as the individual may agree to;

“(B) to serve in a health professional needs area in a health discipline, specialty, or a subspecialty for which the area, population, or facility is designated as a health professional needs area under section 340H; and

“(C) to agree to apply to the loan repayment program under subpart III in that year.

“(2) The term ‘primary health services’ has the meaning given to such term in section (g); and

“(3) the Secretary shall take into account the extent to which such individual is financially independent in determining whether to require or authorize the submission of such information regarding such individual’s family members.

“(b) REVISED GUIDELINES.—The Secretary of Health and Human Services shall—

“(1) strike the second sentence of section 7526(b)(1) of title 42, Code of Federal Regulations; and

“(2) make such other revisions to guidelines and regulations in effect as of the date of the enactment of this Act as may be necessary for consistency with the amendments made by paragraph (1).

SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.
(a) In General.—Section 735 (42 U.S.C. 292y) is amended—
(1) by redesigning subsection (f) as subsection (g); and
(2) by inserting after subsection (e) the following:

“(f) DETERMINATION OF FINANCIAL NEED.—The Secretary—

“(1) may require, or authorize a school or other entity to require, the submission of financial information to determine the financial resources available to any individual seeking assistance under this subpart; and

“(2) shall take into account the extent to which such individual is financially independent in determining whether to require or authorize the submission of such information regarding such individual’s family members.

“(b) REVISED GUIDELINES.—The Secretary of Health and Human Services shall—

“(1) strike the second sentence of section 7526(b)(1) of title 42, Code of Federal Regulations; and

“(2) make such other revisions to guidelines and regulations in effect as of the date of the enactment of this Act as may be necessary for consistency with the amendments made by paragraph (1).

SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL PEDIATRICS, GERMAL INTERNAL MEDICINE, GENERAL PEDIATRICS, GERIATRICS, AND PHYSICIAN ASSISTANTS.
Section 747 (42 U.S.C. 293k) is amended—
(1) by inserting before the section heading, renumbering the following paragraphs, and inserting the following:

“(a) PROGRAM.—The Secretary shall establish a program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338H.

“(b) INSUFFICIENT NUMBER OF APPLICANTS.—If there are an insufficient number of applicants for loan repayments under this subpart to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of recruiting applicants and entering into contractual obligations so as to ensure a sufficient number of participants in the National Health Service Corps for the following year.

“(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338H.

“(d) APPROPRIATIONS FOR RESEARCH.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338H.

“(e) INDIVISIBLE OF NUMBER OF APPLICANTS.—If there are an insufficient number of loan repayments under this subpart to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of recruiting applicants and entering into contractual obligations so as to ensure a sufficient number of participants in the National Health Service Corps for the following year.

“(f) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this subpart.

“(g) ALLOCATION.—The amount of funds obligated under this subpart each fiscal year for loan repayments—

“(1) $70,000,000 shall be for physicians and other health professionals providing primary health services; and

“(2) $70,000,000 shall be for health professionals described in paragraph (1).

SEC. 2214. PEDIATRIC PRIMARY CARE TRAINING AND ENHANCEMENT.
(a) IN GENERAL.—Section 735 (42 U.S.C. 292y) is amended—
(1) by redesigning subsection (f) as subsection (g); and
(2) by inserting after subsection (e) the following:

“(f) PRIMARY CARE TRAINING AND ENHANCEMENT.—

“(1) the Secretary shall establish a program to carry out an enhancement of a primary care training and capacity building program consisting of awarding grants and contracts under subparts (b) and (c).

“(2) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

“(1) IN GENERAL.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

“(A) to plan, develop, operate, or participate in an accredited professional training
(c) DEFINITION.—In this section, the term ‘health disparities’ has the meaning given in section 3171.

SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN EVIDENCE-BASED SETTINGS.

Title VII (42 U.S.C. 292 et seq.) is amended—
(1) by redesignating section 748 as 749A; and
(2) by inserting after section 747 the following:

SEC. 748. TRAINING OF MEDICAL RESIDENTS IN EVIDENCE-BASED SETTINGS.

(a) PROGRAM.—The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants and contracts under this section.

(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—
(1) to plan and develop a new primary care residency training program, which may include—
(A) planning and developing curricula;
(B) recruiting and training residents and faculty; and
(C) other activities designated to result in accreditation of such a program;
(2) to operate or participate in an established primary care residency training program, which may include—
(A) planning and developing curricula;
(B) recruitment and training of residents; and
(C) retention of faculty.

(c) ELIGIBLE ENTITY.—To be eligible to receive a grant or contract under subsection (b), an entity shall—
(A) be a primary care residency program, which may include—
(1) a medical school or teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program;
(2) a public or private nonprofit entity; or
(3) a consortium of 2 or more entities described in subparagraphs (A) and (B).

(d) CAPACITY BUILDING IN PRIMARY CARE.—

(1) IN GENERAL.—The Secretary shall make grants to, or enter into contracts with, eligible entities to establish, maintain, or improve—
(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of family medicine, general internal medicine, general pediatrics, or geriatrics;

(B) programs to improve clinical teaching in such specialties.

(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall—
(A) have demonstrated appropriate involvement of, and an agreement with, a teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program; or

(B) have been designated as described in paragraph (1) or (2), not be an applicant as described in paragraph (3), and have demonstrated appropriate involvement of an accredited training hospital to carry out the inpatient responsibilities associated with a primary care residency training program.

(3) PREFERENCES.—In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—
(A) provide services to underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs);

(B) provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such program, and who plan to specialize or work in family medicine, general internal medicine, general pediatrics, or geriatrics;

(C) to plan, develop, operate, or participate in an accredited program for the training of physicians who plan to teach in family medicine, general internal medicine, general pediatrics, or geriatrics;

(D) to provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such program and who plan to teach in a family medicine, general internal medicine, general pediatrics, or geriatrics training program including in community-based settings;

(E) to plan, develop, operate, or participate in an accredited program for physician assistant education for the training of individuals who plan to teach in programs to provide such training.

(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be—
(A) an accredited school of medicine or osteopathic medicine, public or nonprofit private hospital, or physician assistant training program;

(B) a public or private nonprofit entity; or

(C) a consortium of 2 or more entities described in subparagraphs (A) and (B).

(a) PROGRAM.—The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants and contracts under this section.

(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—
(1) to plan and develop a new primary care residency training program, which may include—
(A) planning and developing curricula;
(B) recruiting and training residents and faculty; and
(C) other activities designated to result in accreditation of such a program;
(2) to operate or participate in an established primary care residency training program, which may include—
(A) planning and developing curricula;
(B) recruitment and training of residents; and
(C) retention of faculty.

(c) ELIGIBLE ENTITY.—To be eligible to receive a grant or contract under subsection (b), an entity shall—
(1) be designated as a recipient of payment for the direct costs of medical education under section 1886(k) of the Social Security Act;
(2) be designated as an approved teaching health center under section 150(d) of the Affordable Care Act; and
(3) be an applicant for designation described in paragraph (1) or (2) and have demonstrated appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program;

(d) PREFERENCES.—In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—
(A) support an existing or new program that—
(i) is accredited by the Accreditation Council for Graduate Medical Education; or

(ii) is accredited by the American Academy of Family Physicians;

(B) in the case of entities seeking awards described in subparagraph (A) and (B), actively applying to establish a training program for oral health professionals; and

(C) in the case of entities seeking awards described in subparagraph (A) and (B), actively applying to establish a training program for dental hygienists.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

Title VII (42 U.S.C. 292 et seq.) is amended—
(1) in section 791(a)(1), by striking ‘‘747 and’’ and inserting ‘‘749, 749A, and’’; and
(2) by inserting after section 748, as added, the following:

SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

(a) PROGRAM.—The Secretary shall establish a training program for oral health professionals consisting of awarding grants and contracts under this section.

(b) SUPPORT AND DEVELOPMENT OF ORAL HEALTH PROFESSIONAL TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—
(1) to plan, develop, operate, or participate in a new or an expanded training program for oral health professionals;

(2) to provide financial assistance to oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public health dentistry, or dental hygiene;

(3) to plan, develop, operate, or participate in a program for the training of oral health professionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

(4) to provide financial assistance in the form of traineeships and fellowships to oral health professionals who plan to teach in...
SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.

(a) Promotional grants for the promotion of a special health need—For the purpose of carrying out subpart XI of part D of title III and sections 747, 748, and 749, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

(1) $240,000,000 for fiscal year 2011.
(2) $253,000,000 for fiscal year 2012.
(3) $265,000,000 for fiscal year 2013.
(4) $278,000,000 for fiscal year 2014.
(5) $292,000,000 for fiscal year 2015.

(b) Existing authorizations of appropriations—Subsection (g)(1), as so redesignated, of section 747 (42 U.S.C. 293k) is amended by striking "2002" and inserting "2015".

SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS AND LOAN REPAYMENTS.

(a) Study.—The Comptroller General of the United States shall conduct a study to determine the effectiveness of scholarship and loan repayment programs under subparts III and XI of part D of title III of the Public Health Service Act, as amended or added by sections 2201 and 2211, including whether scholarships or loan repayments are more effective in:

(1) including physicians, and other providers, to pursue careers in primary care specialties;
(2) retaining such primary care providers; and
(3) encouraging such primary care providers to practice in underserved areas.

(b) Report.—Not later than 12 months after the date of enactment of this Act, the Comptroller General shall submit to the Congress a report on the study under subsection (a) that includes:

(1) an evaluation of the effectiveness of the programs described in subsection (a); and
(2) recommendations as to how the programs described in subsection (a) may be improved.

Subtitle B—Nursing Workforce

SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) Definitions.—Section 801 (42 U.S.C. 296 et seq.) is amended—

(1) in paragraph (1), by inserting "nurse-managed health centers," after "nursing centers," and
(2) by adding at the end the following:

"(16) Nurse-managed health center.—The term 'nurse-managed health center'—(A) means a health care facility, program, or project in which nurse-managed practice is used and the nurse is accountable for the health status of the persons served and for the quality of the services provided. Nurse-managed practice means the delivery of health care services, including health education and health care decided by nurses, through collaborative decision-making with other health care providers.

(b) Nurse Faculty Loan Program.—Paragraph (c) of section 861(c) (42 U.S.C. 297b-1(c)) is amended by striking "$35,000, plus, beginning with fiscal year 2007, an amount determined by the Secretary on an annual basis to reflect inflation." and inserting "$3,300"; and

(c) Additional Education and Loan Repayment Programs.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.

(b) Directive and Conforming Amendments.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by moving section 810 (relating to the establishment of nursing education, practice, and retention grants) from part G to part F; and
(2) by redesignating section 814 as section 814(f).

(9) in part I—

(8) in part G—

(9) in part I—

(3) in section 839, by striking "839" and all that follows through "(a)" and inserting "839, (a)".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "841, (a)".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "871, (a)".

(d) Advanced Education Nursing Grants.—Section 811(c) (42 U.S.C. 296c(c)) is amended—

(1) by striking paragraph (2);
(2) by redesignating paragraph (3) as paragraph (2); and
(3) in paragraph (2), as so redesignated, by striking "that agrees" and all that follows through the semicolon and inserting "that agrees to provide services to providers to serve for a period of not less than 2 years—".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "871, (a)".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "871, (a)".

(e) Technical and Conforming Amendments.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.

(b) Directive and Conforming Amendments.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by moving section 810 (relating to the establishment of nursing education, practice, and retention grants) from part G to part F; and
(2) by redesignating section 814 as section 814(f).

(9) in part I—

(3) in section 839, by striking "839" and all that follows through "(a)" and inserting "839, (a)".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "871, (a)".

(d) Advanced Education Nursing Grants.—Section 811(c) (42 U.S.C. 296c(c)) is amended—

(1) by striking paragraph (2);
(2) by redesignating paragraph (3) as paragraph (2); and
(3) in paragraph (2), as so redesignated, by striking "that agrees" and all that follows through the semicolon and inserting "that agrees to provide services to providers to serve for a period of not less than 2 years—".

(9) in section 835(b), by striking "841" and all that follows through "(a)" and inserting "871, (a)".

(e) Technical and Conforming Amendments.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.
SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

(For the purpose of carrying out this title, in addition to any other amounts authorized to be appropriated for such purposes, there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, such sums as may be necessary—

(1) $115,000,000 for fiscal year 2011.

(2) $122,000,000 for fiscal year 2012.

(3) $127,000,000 for fiscal year 2013.

(4) $134,000,000 for fiscal year 2014.

(5) $140,000,000 for fiscal year 2015.

The monies in the Public Health Investment Fund are authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, such sums as may be necessary—

SEC. 340M. PUBLIC HEALTH WORKFORCE REIMBURSEMENT.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Reimbursement Program referred to in this section as the ‘Program’ for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.

SEC. 873. FUNDING, LOAN REPAYMENT, AND SCHOLARSHIP PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.

SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REIMBURSEMENT.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Reimbursement Program referred to in this section as the ‘Program’ for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.

SEC. 874. FUNDING, SCHOLARSHIP, AND LOAN REIMBURSEMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

SEC. 340O. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.

SEC. 875. FUNDING, SCHOLARSHIP, AND LOAN REIMBURSEMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.

SEC. 340P. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in subsection (b).

(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

(i) have a graduate degree from an accredited school or program of public health;

(ii) have demonstrated expertise in public health.

(c) PAYMENTS.—The payments under this section shall be made on behalf of the individual by the Secretary on a monthly basis to reflect inflation.
the Secretary on an annual basis to reflect inflation) on behalf of the individual for loans described in paragraph (1).

(2) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary under paragraph (1) shall provide for repayment of loan repayments in accordance with this paragraph.

(3) Prevention and Public Health Fund.—The Secretary shall make no later than the end of the fiscal year in which the individual completes such year of service.

(e) Application of Certain Provisions.—The provisions of subsection (a) and (b) shall be applied in a manner consistent with this subsection to the loan repayment program under this section in the same manner and to the same extent as applied to the Public Health Service Corps Loan Repayment Program established under section 338B.

SEC. 2252. ENHANCING THE PUBLIC HEALTH WORKFORCE.

Section 765 (42 U.S.C. 295) is amended to read as follows:

"SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.

"(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall establish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

"(b) GRANTS AND CONTRACTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

"(1) to plan, develop, operate, or participate in, an accredited professional training program in the field of public health (including such a program in nursing; health administration; management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine) for members of the public health workforce, including midcareer professionals;

"(2) to provide financial assistance in the form of traineeships and fellowships to students who are participants in any such program and who plan to specialize or work in the field of public health;

"(3) to plan, develop, operate, or participate in the training of public health professionals who plan to teach in any program described in paragraph (1); and

"(4) to provide financial assistance in the form of traineeships and fellowships to public health professionals who are participants in any program described in paragraph (1) and who plan to teach in the field of public health.

"(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

"(1) an accredited health professions school or program of public health; or

"(2) a State, local, or tribal health department.

"(d) PREFERENCES.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that—

"(1) have financial need;

"(2) demonstrate that the entity will meet the needs of the population served by the entity;

"(3) certify that funds received under this section will be used for the purpose stated in the application; and

"(4) are innovative.

SEC. 2253. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

Section 766 (42 U.S.C. 295c) is amended to read as follows:

"SEC. 766. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

"(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents and graduate public health residents in preventive medicine specialties.

"(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

"(1) an accredited school of public health or school of medicine or osteopathic medicine;

"(2) an accredited public or private nonprofit hospital;

"(3) a State, local, or tribal health department; or

"(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

"(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

"(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

"(2) defray the costs of practicum experiences, as required in such a program; and

"(3) establish, maintain, or improve—

"(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

"(B) programs that improve clinical teaching in preventive medicine and public health.

"(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

SEC. 2254. FELLOWSHIPS REGARDING FACULTY FOR DIVERSITY AND CULTURAL COMPETENCY.

Section 770 (42 U.S.C. 295d) is amended to read as follows:

"SEC. 770. FELLOWSHIPS REGARDING FACULTY FOR DIVERSITY AND CULTURAL COMPETENCY.

"(a) GRANTS.—The Secretary shall establish a fellowship program to provide grants to, or enter into contracts with, eligible entities—

"(1) to provide financial assistance in the form of traineeships and fellowships to public health professionals who plan to teach in a program in preventive medicine or public health.

"(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

"(1) an accredited school of public health or school of medicine or osteopathic medicine;

"(2) an accredited public or private nonprofit hospital;

"(3) a State, local, or tribal health department; or

"(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

"(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

"(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

"(2) defray the costs of practicum experiences, as required in such a program; and

"(3) establish, maintain, or improve—

"(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

"(B) programs that improve clinical teaching in preventive medicine and public health.

"(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

SEC. 2255. CULTURAL AND LINGUISTIC COMPETENCY TRAINING PROGRAM.

Section 775 (42 U.S.C. 295e) is amended to read as follows:

"SEC. 775. CULTURAL AND LINGUISTIC COMPETENCY TRAINING PROGRAM.

"(a) GRANTS.—The Secretary shall establish a cultural and linguistic competency training program for health professionals, including nurse practitioners, consisting of awarding grants and contracts under subsection (b).

"(b) CULTURAL AND LINGUISTIC COMPETENCY TRAINING.—The Secretary shall award grants..."
to, or enter into contracts with, eligible enti-
ties—

(a) to test, develop, and evaluate models of cultural and linguistic competency training programs (including continuing education) for health professionals; and

(b) to implement cultural and linguistic competency training programs for health professionals developed under paragraph (1) or otherwise.

(c) Eligibility.—To be eligible for a grant or contract under subsection (b), an entity shall be—

(1) an accredited health professions school or program;

(2) an academic health center;

(3) a public or private nonprofit entity; or

(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

(d) Preferences.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Addressing, or partnering with an entity with experience addressing, the cultural and linguistic competency needs of the popula-
tion to be served through the grant or contract.

(2) Addressing health disparities.

(3) Expertise in the provision of health professionals in regions experiencing significant changes in the cultural and linguistic demographics of popula-
tions, including communities along the United States-Mexico border.

(4) Carrying out activities described in subsection (b) with respect to more than one health profession discipline, specialty, or subspecialty.

(e) Consultation.—The Secretary shall carry out this section in consultation with the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Mi-

nority Health and the National Center on Minority Health and Health Disparities.

(f) Definition.—In this section, the term ‘health disparities’ has the meaning given to the term in section 3171.

(g) Report.—The Secretary shall submit to the Congress an annual report on the pro-
cram carried out under this section.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

Subpart 1 of part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

* * *

SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

(a) ADVISORY COMMITTEE.—The Secretary, acting through the Assistant Secretary for Health, shall establish a permanent advisory committee to be known as the Advisory Committee on Health Workforce Evaluation and Assessment (referred to in this section as the ‘Advisory Committee’) to develop and implement an integrated, coordinated, and strategic national health workforce policy reflective of current and evolving health workforce needs.

(b) RESPONSIBILITIES.—The Advisory Committee shall—

(1) not later than 1 year after the date of the establishment of the Advisory Com-
mitee, submit recommendations to the Sec-

try on—

(A) classifications of the health work-
force to ensure an accurate collection of data on the health workforce; and

(B) based on such classifications, stan-

dardized methodologies and procedures to

enumerate the health workforce; and

(2) not later than 2 years after the date of the establishment of the Advisory Com-
mitee, submit recommendations to the Sec-

try on—

(A) the supply, diversity, and geographic distribution of the health workforce;

(B) the retention and expansion of the health workforce (including a long-term basis) to ensure quality and adequacy of such workforce; and

(C) policies to carry out the recommenda-
tions made pursuant to subparagraphs (A) and (B); and

(3) not later than 4 years after the date of the establishment of the Advisory Com-
mitee, and every 2 years thereafter, submit updated recommendations to the Secretary under paragraphs (1) and (2).

(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Advisory Committee, including coordinating and supporting the dissemination of the recommendations of the Advisory Com-
mitee.

(d) Membership.—

(1) NUMBER: APPOINTMENT.—The Secretary shall appoint 14 members to serve on the Ad-

visory Committee.

(2) TERMS.—
Interdisciplinary, Community-Based Linkages (as authorized in section 756), the Advisory Council on Graduate Medical Education (as authorized in section 762), and the National Advisory Council on Nursing Education and Practice (as authorized in section 851).

(4) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of that Act, as amended, and that the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

(b) Report.—The Secretary shall submit to the Congress an annual report on the activities of the Advisory Committee.

(1) In this section, the term ‘‘health workforce’’ includes all health care providers with direct patient care and support responsibilities, including physicians, nurse practitioners, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)(2)), allied health professionals, mental and behavioral health professionals (as defined in section 776(f)(2)), and public health professionals (including veterinarians engaged in public health practice).''.

PART 4—HEALTH WORKFORCE ASSESSMENT

SEC. 2271. HEALTH WORKFORCE ASSESSMENT.

(a) In General.—Section 761 (42 U.S.C. 294n) is amended—

(1) by redesigning subsection (c) as subsection (a); and

(2) by striking subsections (a) and (b) and inserting the following:

(a) In General.—The Secretary shall, based upon the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 761(a) of the Public Health Service Act, as amended by this section.

(2) Health Professionals Training for Diversity.—For the purpose of carrying out sections 736, 737, 738, 739, and 739A, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, the following:

(1) $90,000,000 for fiscal year 2011.

(2) $97,000,000 for fiscal year 2012.

(3) $100,000,000 for fiscal year 2013.

(4) $104,000,000 for fiscal year 2014.

(5) $110,000,000 for fiscal year 2015.

(b) Existing Authorizations of Appropriations.—

(1) Section 736.—Paragraph (1) of section 736(b) of the Public Health Service Act is amended by striking ‘‘2002’’ and inserting ‘‘2015’’.

(2) Sections 737, 738, and 739.—Subsections (a), (b), and (c) of section 737 are amended by striking ‘‘2002’’ each place it appears and inserting ‘‘2015’’.

(c) Title III—Prevention and Wellness

SEC. 2301. PREVENTION AND WELLNESS.

(a) In General.—The Public Health Service Act (42 U.S.C. 295 et seq.) is amended by inserting after title XXX the following:

TITLE XXXI—PREVENTION AND WELLNESS

Subtitle A—Prevention and Wellness Trust

SEC. 3111. PREVENTION AND WELLNESS TRUST.

(a) In General.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust, out of any moneys in the Public Health Investment Fund, the following:

(1) for fiscal year 2011, $2,400,000,000.

(2) for fiscal year 2012, $2,845,000,000.
Health, the Office on Women’s Health, and the Substance Abuse and Mental Health Services Administration.

(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

(3) As appropriate, nonprofit and for-profit entities.

(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.


**Subtitle C—Prevention Task Forces**

**SEC. 312. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the ‘Task Force’).

(b) RESPONSIBILITIES.—The Task Force shall—

(1) identify clinical preventive services for review;

(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the Task Force’s standards for a grade of A or B;

(6) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

(7) consult with the Task Force on Community Preventive Services established under section 3132; and

(8) as appropriate, in carrying out this section, consider the national strategy under section 3211.

(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

(d) MEMBERSHIP.—

(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

(2) TIME.

(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this title—

(i) 10 shall be appointed for a term of 2 years;

(ii) 10 shall be appointed for a term of 4 years; and

(iii) 10 shall be appointed for a term of 6 years.

(C) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

(A) Health promotion and disease prevention;

(B) Evaluation of research and systematic evidence reviews;

(C) Application of systematic evidence reviews to clinical decisionmaking or health policy;

(D) Clinical primary care in child and adolescent health;

(E) Clinical primary care in adult health, including women’s health;

(F) Clinical primary care in geriatrics;

(G) Clinical counseling and behavioral services for primary care patients.

(4) REPRESENTATION.—(A) The Secretary shall appoint members of the Task Force, the Secretary shall ensure that—

(1) all areas of expertise described in paragraph (3) are represented; and

(2) the members of the Task Force include individuals with expertise in health disparities.

(b) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

(1) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

(A) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

(B) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

(A) Health care consumers and patient groups.

(B) Providers of clinical preventive services, including community-based providers.

(C) Federal departments and agencies, including—

(1) appropriate health agencies and offices within the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health of the National Institutes of Health and Health Disparities, and the Office on Women’s Health; and

(2) as appropriate, other Federal departments and agencies that have a significant impact upon health (as determined by the Secretary).

(D) Private health care payors.

(E) REPRESENTATION.—In accordance with subsection (b)(6), the clinical prevention stakeholders board shall—

(1) recommend clinical preventive services for review by the Task Force;

(2) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

(3) provide the Task regarding draft recommendations by the Task Force; and

(4) assist with efforts regarding dissemination of recommendations by the Director for the purposes of the dissemination and management of conflicts of interest under those sections.

(b) NO PAY; RECEIPT OF TRAVEL EXPENSES.—(1) Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force or the clinical prevention stakeholders board, except members of the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

(c) APPLICATION OF PAGA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

(d) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

**SEC. 313. TASK FORCE ON COMMUNITY PREVENTIVE SERVICES.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a permanent task force to be known as the Task Force on Community Preventive Services (in this section referred to as the ‘Task Force’).

(b) RESPONSIBILITIES.—The Task Force shall—

(1) identify community preventive services for review;

(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

(4) identify gaps in community preventive services research and evaluation and recommend priority areas for such research and evaluation;

(5) pursuant to section 3143(d), determine whether subsidies and rewards are effective; and

(6) as appropriate, with respect to the community prevention stakeholders board in accordance with subsection (f);

(7) consult with the Task Force on Community Preventive Services established under section 3131; and

(8) as appropriate, in carrying out this section, consider the national strategy under section 3111.

(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

(d) MEMBERSHIP.—

(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

(2) TIME.

(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this title—

(i) 10 shall be appointed for a term of 2 years;

(ii) 10 shall be appointed for a term of 4 years; and

(iii) 10 shall be appointed for a term of 6 years.

(C) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

(A) Health promotion and disease prevention;

(B) Application of systematic evidence reviews to clinical decisionmaking or health policy;

(C) Clinical primary care in child and adolescent health;

(D) Clinical primary care in adult health, including women’s health;

(E) Clinical primary care in geriatrics;

(F) Clinical counseling and behavioral services for primary care patients.

(4) REPRESENTATION.—(A) The Secretary shall appoint members of the Task Force, the Secretary shall ensure that—

(1) all areas of expertise described in paragraph (3) are represented; and

(2) the members of the Task Force include individuals with expertise in health disparities.

(b) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

(B) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

(A) Health care consumers and patient groups.

(B) Providers of clinical preventive services, including community-based providers.

(C) Federal departments and agencies, including—

(1) appropriate health agencies and offices within the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health of the National Institutes of Health and Health Disparities, and the Office on Women’s Health; and

(2) as appropriate, other Federal departments and agencies that have a significant impact upon health (as determined by the Secretary).

(D) Private health care payors.

(E) REPRESENTATION.—In accordance with subsection (b)(6), the clinical prevention stakeholders board shall—

(1) recommend clinical preventive services for review by the Task Force;

(2) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

(3) provide the Task regarding draft recommendations by the Task Force; and

(4) assist with efforts regarding dissemination of recommendations by the Director for the purposes of the dissemination and management of conflicts of interest under those sections.

(b) NO PAY; RECEIPT OF TRAVEL EXPENSES.—(1) Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force or the clinical prevention stakeholders board, except members of the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

(c) APPLICATION OF PAGA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

(d) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).
“(iii) 10 shall be appointed for a term of 6 years.

“(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

“(A) Public health;

“(B) Evaluation of research and systematic evidence reviews;

“(C) Disciplines relevant to community preventive services, including health promotion; disease prevention; chronic disease; worksite health; school-site health; qualitative and quantitative analysis; and health economics, policy, law, and statistics.

“(4) In appointing members of the Task Force, the Secretary—

“(A) shall ensure that all areas of expertise described in paragraph (3) are represented;

“(B) shall ensure that such members include sufficient representatives of each of—

“(i) State health officers;

“(ii) local health officers;

“(iii) health care practitioners; and

“(iv) public health practitioners; and

“(C) shall appoint individuals who have expertise in health disparities.

“(e) Appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of the members subject to final approval by the Task Force.

“(f) COMMUNITY PREVENTION STAKEHOLDERS BOARD.—

“(1) IN GENERAL.—The Task Force shall convene a community prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in community preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of community preventive services.

“(2) MEMBERSHIP.—The members of the community prevention stakeholders board shall include representatives of the following:

“(A) Health care consumers and patient groups.

“(B) Providers of community preventive services, including community-based providers.

“(C) Federal departments and agencies, including—

“(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the National Center on Minority Health and Health Disparities, and the Office on Women’s Health; and

“(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

“(D) Private health care payors.

“(3) RESPONSIBILITIES.—In accordance with subsection (b)(6), the community prevention stakeholders board shall—

“(A) recommend to the community prevention services for review by the Task Force;

“(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

“(C) provide feedback regarding draft recommendations by the Director of the Centers for Disease Control and Prevention;

“(D) assist with efforts regarding dissemination of recommendations by the Director of the Centers for Disease Control and Prevention.

“(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the community prevention stakeholders board shall not be considered employees of the Federal Government or the institution on whose behalf they serve.

“(h) dropped.

“SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIVITY COORDINATION.

“In conducting or supporting research on prevention and wellness, the Director of the National Institutes of Health, the Director of the National Institutes of Health, and the heads of other agencies within the Department of Health and Human Services conducting or supporting such research, shall take into consideration the national strategy under section 3121 and the recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services under section 3132.

“SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RESEARCH GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct or award grants to eligible entities to conduct, research in priority areas identified by the Secretary in the national strategy under section 3121 or by the Task Force on Community Preventive Services as required by section 3132.

“(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

“(1) a State, local, or tribal department of health;

“(2) a public or private nonprofit entity; or

“(3) a consortium of 2 or more entities described in paragraphs (1) and (2).

“(c) REPORT.—The Secretary shall submit to the Congress an annual report on the progress of such research and demonstration projects, including any preliminary findings.

“(d) INCLUSION AS ALLOWABLE USE OF COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3121, the Task Force on Clinical Preventive Services determines that a subsidy or reward meets the criteria established under section 3122, the Secretary shall ensure that the subsidy or reward is included in the essential benefits package under the Affordable Care Act.

“(e) NONDISCRIMINATION; NO TIE TO PREMIUM OR COST SHARING.—In carrying out this section, the Secretary shall ensure that any subsidy or reward—

“(1) does not have a discriminatory effect on the basis of any personal characteristic and is not extraneous to the provision of high-quality health care or related services; and

“(2) is not tied to the premium or cost sharing of an individual under any qualified health benefit plan (as defined in section 1001(c)).

“SEC. 3143. RESEARCH ON SUBSIDIES AND REWARDS TO ENCOURAGE WELLNESS AND HEALTHY BEHAVIORS.

“(a) RESEARCH AND DEMONSTRATION PROJECTS.—

“(1) IN GENERAL.—The Secretary shall conduct, or award grants to public or nonprofit private entities to conduct, research and demonstration projects on the use of financial and in-kind subsidies and rewards to encourage individuals and communities to promote wellness, adopt healthy behaviors, and use evidence-based preventive health services.

“(2) FOCUS.—Research and demonstration projects undertaken under paragraph (1) shall focus on—

“(A) tobacco use, obesity, and other prevention and wellness priorities identified by the Secretary in the national strategy under section 3121 or by the Task Force on Community Preventive Services;

“(B) the initiation, maintenance, and long-term sustainability of wellness promotion; adoption of healthy behaviors; and use of evidence-based preventive health services; and

“(C) populations at high risk of preventable diseases and conditions.

“(b) FINDINGS; REPORT.—

“(1) SUBMISSION OF FINDINGS.—The Secretary shall submit the findings of research and demonstration projects under subsection (a) to—

“(A) the Task Force on Clinical Preventive Services established under section 3131 or the Task Force on Community Preventive Services established under section 3132, as appropriate; and

“(B) the Health Benefits Advisory Committee established by section 221 of the Affordable Care Act for America Act.

“(2) REPORT TO CONGRESS.—Not later than 18 months after the initiation of research and demonstration projects under subsection (a), the Secretary shall submit a report to the Congress on the progress of such research and demonstration projects, including any preliminary findings.

“(c) INCLUSION IN ESSENTIAL BENEFITS PACKAGE.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3121, the Task Force on Clinical Preventive Services determines that a subsidy or reward meets the criteria established under section 3122, the Task Force on Community Preventive Services determines that a subsidy or reward is effective, the Secretary shall ensure that the subsidy or reward becomes an allowable use of grant funds section 3131.

“(d) NONDISCRIMINATION; NO TIE TO PREMIUM OR COST SHARING.—In carrying out this section, the Secretary shall ensure that any subsidy or reward—

“(1) does not have a discriminatory effect on the basis of any personal characteristic and is not extraneous to the provision of high-quality health care or related services; and

“(2) is not tied to the premium or cost sharing of an individual under any qualified health benefit plan (as defined in section 1001(c)).

“SEC. 3151. COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program for the delivery of community prevention and wellness services consisting of awarding grants to eligible entities—

“(1) to provide evidence-based, community prevention and wellness services in priority areas identified by the Secretary in the national strategy under section 3121, or by the Task Force on Community Preventive Services as required by section 3132.

“(b) ELIGIBILITY.—

“(1) DEFINITION.—To be eligible for a grant under this section, an entity shall be—

“(A) a State, local, or tribal department of health;

“(B) a public or private entity; or

“(C) a consortium of 2 or more entities described in subparagraph (A) or (B); and

“(ii) may be a community partnership representing a Health Empowerment Zone.

“(3) HEALTH EMPOWERMENT ZONE.—In this subsection, the term ‘Health Empowerment Zone’ means an area—
"(A) in which multiple community prevention and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121; and

"(B) which is represented by a community partnership that demonstrates community support and alignment with State, local, or tribal health departments and includes—

"(i) a broad cross section of stakeholders;

"(ii) residents of the community; and

"(iii) representatives of entities that have a history of working within and serving the community.

"(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to entities that—

«(1) will identify one or more goals or objectives identified by the Secretary in the national strategy under section 3121;

«(2) will address significant health disparities, including those identified by the Secretary in the national strategy under section 3121;

«(3) will address unmet community prevention and wellness needs and avoid duplication of effort;

«(4) have been demonstrated to be effective in community settings, or comparable to the proposed target community;

«(5) will contribute to the evidence base for community prevention and wellness services; and

«(6) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

«(7) demonstrate coordination or collaboration across governmental and nongovernmental partners.

"(d) HEALTH DISPARITIES.—Of the funds awarded under this section for a fiscal year, the Secretary shall award not less than 50 percent for planning or implementing community prevention and wellness services whose primary purpose is to achieve a measurable reduction in one or more health disparities, including those identified by the Secretary in the national strategy under section 3121.

"(e) EMPHASIS ON RECOMMENDED SERVICES.—For fiscal year 2014 and subsequent fiscal years, the Secretary shall award grants under this section only for planning or implementing services recommended by the Task Force on Community Preventive Services under section 3132 or deemed effective based on a review of comparable rigor (as determined by the Director of the Centers for Disease Control and Prevention).

"(f) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

«(1) to build or acquire real property or for construction; or

«(2) for services or planning to the extent that payment has been made, or can reasonably be expected to be made—

«(A) under any insurance policy; and

«(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

«(C) an entity which provides health services on a prepaid basis.

"(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants awarded under this section.

"(h) DEFINITIONS.—In this section, the term ‘evidence-based’ means that methodologically sound research has demonstrated a beneficial health effect, in the judgment of the Director of the Centers for Disease Control and Prevention.

**Subtitle F—Core Public Health Infrastructure**

**SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.**

"(a) PROGRAM.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a comprehensive program consisting of awarding grants under subsection (b),

"(b) GRANTS.—

"(1) AWARD.—For the purpose of addressing core public health infrastructure needs, the Secretary—

«(A) shall award a grant to each State health department; and

«(B) may award grants on a competitive basis to State, local, or tribal health departments.

"(2) ALLOCATION.—Of the total amount of funds awarded as grants under this subsection for a fiscal year—

«(A) not less than 50 percent shall be for grants to State health departments under paragraph (1)(A); and

«(B) not less than 30 percent shall be for grants to local health departments or, to the extent that funds are used by the Secretary to address an unmet core public health infrastructure need, including those identified in the accreditation process under subsection (g).

"(c) USE OF FUNDS.—The Secretary may award a grant to an entity under subsection (b)(1) only if the entity agrees to use the grant to address core public health infrastructure needs, including those identified in the accreditation process under subsection (g).

"(d) FORMULA GRANTS TO STATE HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(A), the Secretary shall award funds to each State health department in accordance with—

«(1) a formula based on population size, burden of preventable diseases and disability, and core public health infrastructure gaps, including those identified in the accreditation process under subsection (g); and

«(2) other factors the Secretary determines are appropriate.

"(e) APPLICATION REQUIREMENTS.—The Secretary, including in the application, shall require—

«(1) a description of the baseline information, health information systems, and public health infrastructure gaps;

«(2) an assurance that the entity will carry out activities to address the core public health infrastructure gaps identified in the application;

«(3) an assurance that the entity will carry out activities to address the public health infrastructure gaps identified in the application;

«(4) a description of the entity’s revenue that is used to support the core public health infrastructure gaps identified in the application;

«(5) the strategy the entity will use to address the core public health infrastructure gaps identified in the application;

«(6) the entity’s plan for sustainability;

«(7) the entity’s plan for any other factors the Secretary determines are appropriate.

"(f) MAINTENANCE OF EFFORT.—The Secretary may award a grant to an entity under subsection (b) only if the entity demonstrates to the satisfaction of the Secretary that the entity’s efforts—

«(1) will support the entity’s efforts to address the core public health infrastructure gaps identified in the application;

«(2) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

«(3) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

«(4) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

«(5) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

«(6) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

«(7) will support the entity’s efforts to address the public health infrastructure gaps identified in the application;

"(g) ESTABLISHMENT OF A PUBLIC HEALTH ACCREDITATION PROGRAM.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

«(A) establish a process for the submission, review and update, standards for voluntary accreditation of State, local, or tribal health depart-

"ments and public health laboratories for the purpose of ensuring that the performance of such departments and laboratories is in accordance with such standards.

"(2) COOPERATIVE AGREEMENT.—The Secretary may enter into a cooperative agreement with a private nonprofit entity to carry out paragraph (1).
and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(3) MEMBERS ALREADY SERVING.—

(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select the individuals already serving on the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(B) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall not include any period of service by the member on the Preventive Services Task Force or the Task Force on Community Preventive Services, respectively, as in existence on the day before the date of enactment of this Act.

(c) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the national strategy under section 3121 of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services, acting through the relevant agency head, may make a judgment about how the strategy will address an issue and rely on such judgment in carrying out any provision of title C, D, E, or F of title XXXI of such Act, as added by subsection (a), that requires the Secretary—

(1) to take into consideration such strategy;

(2) to conduct or support research or provide services in priority areas identified in such strategy; or

(3) to take any other action in reliance on such strategy.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (61) of section 3(b) of the Indian Health Care Improvement Act (25 U.S.C. 1602) and section 19(1) of the SCHIP Benefits Improvement and Pro- tection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(2) Section 126 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Pro- tection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking “United States Preventive Services Task Force” wherever it appears and inserting “Task Force on Clinical Preventive Services”.

(3) Paragraph (7) of section 317(a) of the Public Health Service Act (42 U.S.C. 300a–5(a)) is amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(4) Section 915 of the Public Health Service Act (42 U.S.C. 299–4) is amended by striking subsection (a).

(5) Sections (a)(2)(AA)(i)(I), (xx)(1), and (ddd)(1)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x) are amended by striking “United States Preventive Services Task Force” wherever it appears and inserting “Task Force on Clinical Preventive Services”.

(e) IDENTIFYING EXISTING BEST PRACTICES.—The Director shall identify best practices that are—

(1) currently utilized by health care providers (including hospitals, physicians, and other clinician practices, community co- operatives, and other health care entities) that deliver consistently high-quality, effective health care services; and

(2) easily adapted for use by other health care providers and for use across a variety of health care settings.

(f) DEVELOPING NEW BEST PRACTICES.—The Director shall develop best practices that are—

(1) based on a review of existing scientific evidence;

(2) sufficiently detailed for implementa- tion and incorporation into the workflow of health care providers; and

(3) designed to be easily adapted for use by health care providers across a variety of health care settings.

(g) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation—

(1) shall include determinations of which best practices—

(A) most reliably and effectively achieve significant improvement in improving the quality of patient care; and

(B) are easily adapted for use by health care providers across a variety of health care settings;

(2) shall include regular review, updating, and improvement of such best practices; and

(3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community co- operatives, and other health care entities) and simulations of such best practices for determinations under paragraph (1).

(h) IMPLEMENTATION OF BEST PRACTICES.—

(1) IN GENERAL.—The Director shall enter into arrangements with entities in a State or region to implement best practices identified or developed under this section. Such imple- mentation—

(A) may include forming collaborative multi-institutional teams; and

(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.

(2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—

(A) have the greatest impact on patient outcomes and satisfaction;

(B) are the most easily adapted for use by health care providers across a variety of health care settings;

(C) promote coordination of health care practitioners across the continuum of care; and

(D) engage patients and their families in improving patient care and outcomes.

(3) PUBLIC DISSEMINATION OF INFORMATION.—The Director shall provide for the public dissemination of information with re- spect to best practices and activities under this section. Such information shall be made available in appropriate formats and lan- guages to reflect the varying needs of con- sumers and diverse levels of health literacy.

(i) REPORT.—

(1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

(2) CONTENT.—Each report under para- graph (1) shall include—

(A) information on activities conducted pursuant to grants and contracts awarded;
“(B) summary data on patient outcomes before, during, and after implementation of best practices; and
“(C) recommendations on the adaptability of best practices for use by health providers.”.

(b) Initial Quality Improvement Activities and TIES to Be Implemented—Until the Director of the Agency for Healthcare Research and Quality has established initial priorities under section 308(b) of the Public Health Service Act, as added by subsection (a), the Director shall, for purposes of such section, prioritize the following:

(1) Health Care-associated Infections.—Reducing health care-associated infections, including infections in nursing homes and outpatient settings.

(2) Surgery.—Increasing hospital and outpatient perioperative patient safety, including reducing surgical-site infections and surgical errors (such as wrong-site surgery and retained foreign bodies).

(3) Emergency Room.—Improving care in hospital emergency rooms, including through the use of principles of efficiency design and delivery to improve patient flow.

(4) Obstetrics.—Improving the provision of obstetrical and neonatal care, including the implementation of interventions that are effective in reducing the risk of preterm and premature labor and the implementation of best practices for labor and delivery care.

(5) Preventing the provision of preventable and developmental child health services, including interventions that can reduce child health disparities (as defined in section 3171 of the Public Health Service Act, as added by section 2301) and reduce the risk of developing chronic health-threatening conditions that affect an individual’s life course development.

(c) Report.—Not later than 18 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall submit a report to the Congress on the impact of the nurse-to-patient ratio on the quality of care and patient outcomes, including recommendations for further integration into quality measurement and quality improvement activities.

SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

(a) Establishment.—Title XVII (42 U.S.C. 230a et seq.) is amended—

(1) by redesignating sections 1709 and 1710 as sections 1710 and 1711, respectively; and

(2) by inserting after section 1708 the following:

“SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

“(a) IN GENERAL.—There is established within the Department an Assistant Secretary for Health Information (in this section referred to as the ‘Assistant Secretary’), to be appointed by the Secretary.

“(b) Responsibilities.—The Assistant Secretary shall—

“(1) ensure the collection, collation, reporting, and publishing of information (including full and complete statistics) on key health indicators regarding the Nation’s health and the performance of the Nation’s health care;

“(2) facilitate and coordinate the collection, collation, reporting, and publishing of information regarding the Nation’s health and the performance of the Nation’s health care (other than information described in paragraph (1));

“(3) develop standards for the collection of data regarding the Nation’s health and the performance of the Nation’s health care; and

“(B) in carrying out subparagraph (A)—

“(i) include standards, as appropriate, for the collection of accurate data on health disparities;

“(ii) ensure, with respect to data on race and ethnicity, conformity with the standards and guidelines of the 1997 Office of Management and Budget Standards for Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity (or any successor standards that develop);

“(iv) in consultation with the Director of the Office of Minority Health, and the Director of the Office of Civil Rights of the Department, in the collection, development and publication of data on health and health care with respect to primary language;

“(v) provide support to Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary) for the collection and collation of information described in paragraphs (1) and (2);

“(B) facilitate the sharing of information described in paragraphs (1) and (2) among the agencies of the Department;

“(D) a description of analyses of healthy disparities, including facilitating and funding analyses conducted in cooperation with the Social Security Administration, the Bureau of the Census, and other appropriate agencies and organizations, that are consistent with privacy, proprietary, and other appropriate safeguards, facilitate public accessibility of datasets (such as de-identified Medicare datasets or publicly available data on key health indicators) by means of the Internet; and

“(g) PROPRIETARY AND PRIVACY PROTECTION.—Nothing in this section shall be construed to affect applicable proprietary or privacy protections.

“(h) Consultation.—In carrying out this section, the Assistant Secretary shall consult with—

“(1) the heads of appropriate health agencies and offices in the Department, including the Office of the Secretary of the Public Health Service, the Office of Minority Health, and the Office on Women’s Health; and

“(2) as appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

“(1) DEFINITION.—In this section—

“(1) the terms ‘agency’ and ‘agencies’ include an epidemiology center established under section 214 of the Indian Health Care Improvement Act.

“(2) The term ‘Department’ means the Department of Health and Human Services.

“(B) in carrying out this section, the Assistant Secretary shall conduct and disseminate information on health and health care, including foundations; and

“(c) Request for Information From Departments and Agencies.—With applicable law, the Assistant Secretary may secure directly from any Federal department or agency information necessary to enable the Assistant Secretary to carry out this section.

“(1) Report.—

“(A) submission.—The Assistant Secretary shall submit to the Congress an annual report containing:

“(1) a description of national, regional, or State changes in health or health care, as reflected by the key health indicators identified under subsection (c)(1);

“(B) a description of gaps in the collection, collation, reporting, and publishing of information regarding the Nation’s health and the performance of the Nation’s health care;

“(C) recommendations for addressing such gaps and identification of the appropriate Federal department or other entity to address such gaps;

“(D) a description of analyses of health disparities, including the results of completed and ongoing studies, and proposed or planned research; and

“(E) a plan for actions to be taken by the Assistant Secretary to address gaps described in subparagraph (B).

“(2) Consideration.—In preparing a report under paragraph (1), the Assistant Secretary shall take into consideration the findings and conclusions in the reports under sections 308, 903(a)(6), and 913(b)(2).

“(1) Key Health Indicators.—The Assistant Secretary shall—

“(1) in general.—In carrying out subsection (b)(1), the Assistant Secretary shall—

“(A) identify, and reassess at least once every 3 years, key health indicators described in this subsection;

“(B) publish statistics on such key health indicators for the public—

“(i) not less than annually; and

“(ii) on a supplemental basis whenever warranted by—

“(I) the rate of change for a key health indicator; or

“(II) the need to inform policy regarding the Nation’s health and the performance of the Nation’s health care; and

“(C) ensure consistency with the national strategy developed by the Secretary under section 3212 and consideration of the indicators specified in the reports under sections 308, 903(a)(6), and 913(b)(2).

“(2) Release of Key Health Indicators.—The regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of key health indicators shall be the same as the regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of Principal Federal Economic Indicators (or equivalent statistical data) by the Bureau of Labor Statistics.

“(1) in general.—In carrying out this section, the Assistant Secretary shall coordinate with—

“(C) public and private entities that collect and disseminate information on health and health care, including foundations; and

“(D) the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology.

“(e) Quality and Surveillance.—For the purpose of carrying out part D of title IX and
section 1709, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Service Fund, $300,000,000 for each of fiscal years 2011 through 2015.”.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

SEC. 2501. EXPANSION OF PARTICIPATION IN 340B PROGRAM.

(a) Expansion of Covered Entities Receiving Discounted Prices.—Section 340B(a)(4) (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

“(M) A children’s hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

“(N) An entity that is a critical access hospital as determined under section 1822(c)(2) of the Social Security Act.

“(O) An entity receiving funds under part D of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.

“(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive maternal and child health) for the provision of health care services.

“(Q) An entity receiving funds under subparagraph (ii) of such part B relating to the prevention and treatment of substance abuse for the provision of treatment services for substance abuse.

“(R) An entity that is a Medicare-dependent small rural hospital (as defined in section 1897 of the Social Security Act).

“(S) An entity that is a sole community hospital (as defined in section 1897(d)(5)(C) of the Social Security Act).

“(T) An entity that is classified as a rural referral center under section 1866(d)(5)(C) of the Social Security Act.”.

(b) Prohibition on Group Purchasing Arrangements.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) by adding “and” at the end of clause (i);

(B) by striking “; and” at the end of clause (i) and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), by redesignating subparagraphs (A) through (E) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following:

“(C) Prohibiting Use of Group Purchasing Arrangements.—A covered entity, as described in subparagraph (L), (M), (N), (R), (S), or (T) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.”.

SEC. 2502. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) Integrity Improvements.—Section 340B (42 U.S.C. 256b) is amended—

(1) by striking subsections (c) and (d); and

(2) by inserting after subsection (b) the following:

“(c) Improvements in Program Integrity.—

“(1) MANUFACTURER COMPLIANCE.—

“(A) In general.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

“(B) Improvements.—The improvements described in subparagraph (A) shall include the following:

“(i) The establishment of a process to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under the 340B Program to covered entities, which shall include the following:

“(I) Developing and publishing, through an appropriate policy or regulatory issuance, standards and methodology for the calculation of ceiling prices under such subsection.

“(II) Comparing the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

“(III) Conducting periodic monitoring of sales transactions to covered entities.

“(IV) Inquiring into any discrepancies between ceiling prices and manufacturer pricing data that may be identified and taking or requiring manufacturers to take, corrective action in response to such discrepancies, including the issuance of refunds pursuant to the procedures set forth in section 1886(d)(5)(C).

“(II) Renegotiation of ceiling prices.—In any case in which the Secretary determines, after making all required inquiries and investigations, that the published ceiling prices are not accurate, including in any case in which the Secretary receives a tip, complaint, or other report of an overcharge or other violation of the requirements of this section, the Secretary shall cause the published ceiling prices to be renegotiated.

“(III) Ease of access and use of information.—The Secretary shall ensure that the information available to covered entities from the Secretary to verify the accuracy of ceiling prices calculated by manufacturers includes timely access to the information in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

“(IV) Improvements in program integrity.—The improvements described in subparagraph (A) shall include the following:

“(I) Submission to the Secretary by manufacturers of an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

“(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time.

“(III) Notwithstanding any other provision of law prohibiting the disclosure of ceiling prices or data used to calculate the ceiling price, the provision of access to covered entities and State Medicaid agencies through an Internet website of the Department of Health and Human Services or contractor to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary.

“(IV) Access to information.—A covered entity may request the Secretary to verify the accuracy of information regarding the ceiling prices calculated by manufacturers for covered drugs that are reported to the Secretary or under contracts with the Secretary that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

“(M) A children’s hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

“(N) An entity that is a critical access hospital as determined under section 1822(c)(2) of the Social Security Act.

“(O) An entity receiving funds under part D of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.

“(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive maternal and child health) for the provision of health care services.

“(Q) An entity receiving funds under subparagraph (ii) of such part B relating to the prevention and treatment of substance abuse for the provision of treatment services for substance abuse.

“(R) An entity that is a Medicare-dependent small rural hospital (as defined in section 1897 of the Social Security Act).

“(S) An entity that is a sole community hospital (as defined in section 1897(d)(5)(C) of the Social Security Act).

“(T) An entity that is classified as a rural referral center under section 1866(d)(5)(C) of the Social Security Act.”.

(b) Prohibition on Group Purchasing Arrangements.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) by adding “and” at the end of clause (i); and

(B) by striking “; and” at the end of clause (i) and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), by redesignating subparagraphs (A) through (E) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following:

“(D) Appropriate credits and refunds are issued to covered entities if such rebates, discounts, or other price concessions have been insufficient to reasonably ensure compliance.

“(E) The imposition of sanctions in the form of civil monetary penalties, which—

“(I) shall be assessed according to standards and procedures established in regulations promulgated by the Secretary, and

“(II) shall not exceed $5,000 for each violation; and

“(III) shall apply to any covered entity that knowingly commits references to subparagraph (a)(5)(B) or knowingly violates any other provision of this section.

“(V) The establishment of a requirement that providers of covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

“(VI) The establishment of a requirement that providers of covered drugs under this section, for a period of time to be determined by the Secretary, in cases in which the Secretary determines, in accordance with standards and procedures established in regulations, that—

“(I) a violation of a requirement of this section was repeated and knowing; and

“(II) the imposition of a monetary penalty would be insufficient to reasonably ensure compliance.

“(VII) The referral of matters as appropriate to the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies.

“(VIII) Administrative Dispute Resolution Process.—From amounts appropriated under paragraph (4), the Secretary may establish and implement an administrative process for the resolution of the following:

“(A) Claims by covered entities that manufacturers have violated the terms of their
agreement with the Secretary under subsection (a)(1).

“(B) Claims by manufacturers that covered entities have violated subsection (a)(5)(A) or (a)(6) of section 340b(a) shall apply to drugs dispensed on or after such date."

(2) Section 340b(a)(2) (42 U.S.C. 256b(a)(2)) is amended—

(A) by adding at the end of paragraph (1) the following: “(5) The component information used to calculate the ceiling price as determined necessary to administer the requirements of the program, and the Secretary shall—"

(B) by adding a new paragraph (6) to read as follows: “(6) The Secretary may, in determining the amount of a grant under this section, refuse to award grants for activities that do not meet the requirements of this section only if the Secretary demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the State health clinic program for the activities being sponsored by the grant."

(3) Subsection (a) of section 340b(a) (42 U.S.C. 256b(a)) is amended—

(A) by adding at the end the following: “(5) The component information used to calculate the ceiling price as determined necessary to administer the requirements of the program, and the Secretary shall—"

(B) by adding a new paragraph (6) to read as follows: “(6) The Secretary may, in determining the amount of a grant under this section, refuse to award grants for activities that do not meet the requirements of this section only if the Secretary demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the State health clinic program for the activities being sponsored by the grant."

SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.

(a) Program.—The Secretary shall establish a school-based health clinic program consisting of awarding grants to eligible entities to support the operation of school-based health clinics (referred to in this section as ‘SBHCs’).

(b) Eligibility.—To be eligible for a grant under this section, an entity shall—

1. be an SBHC (as defined in subsection (1)(3)); and

2. submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum—

(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

(B) evidence of local need for the services to be provided by the SBHC;

(C) an assurance that—

(i) SBHC services will be provided in accordance with Federal, State, and local laws;

(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

(iii) the SBHC will provide on-site health services during the academic day when school is in session and has an established network of support from local public and private health providers when the school or SBHC is closed;

(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school; and

(v) the SBHC’s governing facility assumes all responsibility for the SBHC administration, operations, and oversight; and

(D) such other information as the Secretary may require.

(c) Use of Funds.—Funds awarded under a grant under this section may be used for—

1. providing training related to the provision of comprehensive primary health services and additional health services;

2. the management and operation of SBHC programs, including through subcontracts; and

3. the payment of salaries for health professionals and other appropriate SBHC personnel;

(d) Consideration of Need.—In determining the amount of a grant under this section, the Secretary shall take into consideration—

1. the financial need of the SBHC;

2. State, local, or other sources of funding provided to the SBHC; and

3. other factors as determined appropriate by the Secretary.

(e) Preferences.—In awarding grants under this section, the Secretary shall give preference to SBHCs that have a demonstrated record of service to at least one of the following:

1. a high percentage of medically underserved children; and

2. Communities or populations in which children and adolescents have difficulty accessing health and mental health services.

(f) Communities.—In awarding grants under this section only if the Secretary demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the State health clinic program for the activities being sponsored by the grant."

(g) Supplement, Not Supplant.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the SBHC for the operation of such clinic (including any activities described in paragraph (1) or (2) of subsection (c)).

(h) Payor of Last Resort.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will not be used for any activities that the payment has been made, or can reasonably be expected to be made—

1. under any insurance policy; and

2. under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

3. by an entity which provides health services on a prepaid basis.

(i) Regulations Regarding Reimbursement for Health Services.—The Secretary shall issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including reimbursement for services provided through an insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act)

(j) Evaluation; Report.—The Secretary shall—

1. develop and implement a plan for evaluating SBHCs and monitoring quality performances under the awards made under this section; and

2. submit to the Congress on an annual basis a report on the program under this section.

(k) Definitions.—In this section:

1. Comprehensive Primary Health Services.—The term ‘comprehensive primary health services’ means the core services offered by SBHCs, which—

(a) shall include—

(i) comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions and referrals to, and followup for, specialty care; and

(ii) mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of care, including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

(b) under funds received through the grant

1. may include additional services, such as oral health, social, and age-appropriate health education services, including nutritional counseling.

2. Medically Underserved Children and Adolescents.—The term ‘medically underserved children and adolescents’ means a population of children and adolescents who are residents of an area designated by the Secretary as an area with a shortage of personal health services and health infrastructure for such children and adolescents.

3. School-Based Health Clinic.—The term ‘school-based health clinic’ means a health clinic that—

SEC. 399Z–2. EFFECTIVE DATE.

(a) In General.—The amendments made by this subtitle shall take effect on the date of enactment of this Act, and sections 2501, 2502(b), and 2502(b)(2) apply to drugs dispensed on or after such date.

(b) Effectiveness.—The amendments made by this subtitle shall be effective, and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of this section only if the Secretary demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the State health clinic program for the activities being sponsored by the grant.
"(A) is located in, or is adjacent to, a school facility of a local educational agency; "(B) is organized through school, community, and health provider relationships; "(C) is administered by a sponsoring facility; "(D) provides comprehensive primary health services during school hours to children and families by health professionals in accordance with State and local laws and regulations, established standards, and community practice; and "(E) does not include abortion services.

"(4) SPONSORING FACILITY.—The term ‘sponsoring facility’ is—

"(A) a hospital; 
"(B) a public health department; 
"(C) a community health center; 
"(D) a nonprofit health care entity whose mission is to provide access to comprehensive primary health care services; 
"(E) a local educational agency; or 
"(F) a program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act, a Native Hawaiian entity, or an urban Indian program under Title II of the Indian Health Care Improvement Act.

"(m) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there shall be made available to carry out this section $50,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015."

SEC. 3513. FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.

Section 1913 (42 U.S.C. 254d) is amended—

(1) in subsection (a)(2)(A), by striking ‘community mental health services’ and inserting ‘behavioral health services (of the type offered by federally qualified behavioral health centers consistent with subsection (c)(3))’; 
(2) in subsection (b) —

(A) by striking paragraph (1) and inserting the following—

‘(1) services under the plan will be provided only through appropriate, qualified community programs which may include federally qualified behavioral health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer support programs, and mental health primary consumer-directed programs; and’; and 
(B) in paragraph (2), by striking ‘community mental health centers’ and inserting ‘federally qualified behavioral health centers’; and 
(3) by striking subsection (c) and inserting the following—

‘(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

(1) IN GENERAL.—The Administrator shall certify and recertify at least every 5 years, federally qualified behavioral health centers as meeting the criteria specified in this subsection.

(2) REGULATIONS.—Not later than 18 months after the date of the enactment of the Affordable Health Care for America Act, the Administrator shall issue final regulations to determine the certification criteria for certifying centers under paragraph (1).

(3) CRITERIA.—The criteria referred to in subsection (b)(2) are that the center performs the following:

(A) Provide services in locations that ensure services will be available and accessible promptly and in a manner which preserves patient dignity and assures continuity of care.

(B) Provide services in a mode of service delivery appropriate for the target population.

(C) Provide individuals with a choice of service options where there is more than one efficacious treatment.

(D) Employ a diverse staff of clinical and support staff that is multidisciplinary and culturally and linguistically competent.
(E) Provide services, within the limits of the capacities of the center, to any individual residing or employed in the service area of the center.

(f) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

(g) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeudtic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(h) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(j) Targeted case management (services to assist individuals gaining access to needed medical, educational, and other services and applying for income security and other benefits to which they may be entitled).

(k) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(l) Targeted case management (services to assist individuals gaining access to needed medical, educational, and other services and applying for income security and other benefits to which they may be entitled).

(m) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(n) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(o) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(p) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(q) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(r) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(s) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(t) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(u) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(v) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(w) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(x) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(y) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.

(z) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutictic foster care services, multisystemic therapy, and other evidence-based practices as the Secretary may require.
completing specialty training or certification programs and to establish incentives for nurses to assume faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume an full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing and other educational institutions, community colleges and other academic institutions providing associate’s, bachelor’s, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that:

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nursing faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include:

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, and patient safety measures); and

(H) an increase in the diversity of new graduate nurses relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.

Part E of title VII (42 U.S.C. 291 et seq.) is amended by adding at the end the following:

"Subpart 3—Mental and Behavioral Health Training

SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAM.

(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Administrator of Health and Human Services, shall establish an interdisciplinary mental and behavioral health training program consisting of awarding grants and scholarships for training (5)

(b) SUPPORT AND DEVELOPMENT OF MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, operate, or participate in an accredited professional training program for mental and behavioral health professionals to promote—

(A) interdisciplinary training; and

(B) coordination of the delivery of health care within health centers, including health care institutions, community-based settings, and the patient’s home;

(2) to provide financial assistance to mental and behavioral health professionals, who are participants in any such program, and who plan to work in the field of mental and behavioral health;

(3) to plan, develop, operate, or participate in an accredited program for the training of mental and behavioral health professionals who plan to teach in the field of mental and behavioral health;

(4) to provide financial assistance in the form of traineeships and fellowships to mental and behavioral health professionals who are participants in any such program and who plan to teach in the field of mental and behavioral health.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

(1) an accredited health care profession school of psychology, psychiatry, social work, marriage and family therapy, professional mental health or substance abuse counseling, or addiction medicine;

(2) an accredited public or nonprofit private hospital;

(3) a public or private nonprofit entity; or

(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give priority to entities that have a demonstrated record of at least one of the following:

(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

(2) Supporting teaching programs that address the health care needs of vulnerable populations.

(3) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among mental and behavioral health professionals).

(4) Training individuals who serve geriatric populations with an emphasis on underserved elderly.

(5) Training individuals who serve pediatric populations with an emphasis on underserved children.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

"(f) DEFINITION.—In this section:

(1) the term ‘interdisciplinary’ means collaboration across health professions, specialties, and subspecialties, which may include public health, nursing, allied health, dietetics or nutrition, and appropriate health specialties.

(2) the term ‘mental and behavioral health professionals’ means an individual training or practicing—

(A) in psychology; general, geriatric, child or adolescent psychiatry; social work; marriage and family therapy; professional mental health or substance abuse counseling; or addiction medicine; or

(B) another mental and behavioral health specialty, as deemed appropriate by the Secretary.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2011 through 2015. Of the amounts appropriated to carry out this section for a fiscal year, not less than 15 percent shall be used for training programs in psychology.

SEC. 2523. REAUTHORIZATION OF TELEHEALTH AND TELEMEDICINE GRANT PROGRAMS.

(a) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I (42 U.S.C. 254c–14) is amended—

(1) in subsection (a)—

(A) by striking paragraph (3) (relating to frontier communities); and

(B) by inserting after paragraph (2) the following:

(3) HEALTH DISPARITIES.—The term ‘health disparities’ has the meaning given such term in section 3171;";

(2) in subsection (b)(1)—

(A) in subparagraph (B), by striking “and” at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ‘‘; and’’; and

(C) by adding at the end the following:

‘‘(D) reduce health disparities.’’;

(3) in subsection (f)(1)(B)(iii)—

(A) in subclause (VII), by inserting ‘‘, including skilled nursing facilities’’ before the period at the end;

(B) in subclause (IX), by inserting ‘‘, including county mental health and public mental health facilities’’ before the period at the end; and

(C) by adding at the end the following:

‘‘(XIII) Renal dialysis facilities.’’;

(4) by amending subsection (i) to read as follows:

‘‘(i) PREFERENCES.—

(1) TELEHEALTH NETWORKS.—In awarding grants under subsections (d) and (e), the term ‘telehealth networks’ includes networks involving telehealth networks, the Secretary shall give preference to eligible entities meeting at least one of the following:

(A) NETWORK.—The eligible entity is a health care provider in, or proposing to form, a health care network that furnishes services in a medically underserved area or a health professional shortage area.

(B) BROAD GEOGRAPHIC COVERAGE.—The eligible entity demonstrates broad geographic coverage in the rural or medically underserved areas of the State or States in which the entity is located.

(C) HEALTH DISPARITIES.—The eligible entity demonstrates how the project to be funded through the grant will address health disparities.

(D) LINKAGES.—The eligible entity agrees to use the grant to establish or develop plans for telehealth systems that will link rural hospitals and rural health care providers to other hospitals, health care providers, and patients.

(E) EFFICIENCY.—The eligible entity agrees to use the grant to promote greater efficiency in the use of health care resources.

H12768

CONGRESSIONAL RECORD — HOUSE

November 7, 2009
NO CHILD LEFT UNIMMUNIZED AGAINST INFLUENZA: DEMONSTRATION PROGRAM USING ELEMENTARY AND SECONDARY SCHOOLS AS INFUENZA VACCINATION CENTERS.

(a) PURPOSE.—The Secretary of Health and Human Services in consultation with the Secretary of Education, shall award grants to eligible partnerships to carry out demonstration programs designed to test the feasibility of using the Nation’s elementary schools and secondary schools as influenza vaccination centers.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

(3) PROVISION OF TELEHEALTH TECHNICAL ASSISTANCE.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

(3) PROVISION OF TELEHEALTH TECHNICAL ASSISTANCE.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

(b) IN GENERAL.—The Secretary shall coordinate with States to establish partnerships consisting of awarding grants under subsection (d)(2) for the telehealth network.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to projects that meet at least one of the following:

(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(G) SERVICES.—The eligible entity provides a pricing system by which it distinguishes between services provided to eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.
(5) SECRETARY.—Except as otherwise specified, the term “Secretary” means the Secretary of Health and Human Services.

SEC. 2525. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300m–4a) is amended—

(1) by striking the heading and inserting “In General.”;

(A) by striking the heading and inserting “In General.”; and

(B) in the matter preceding paragraph (1), by striking “(A)” and inserting “(A)”.

(2) in subsection (b), by striking “there are authorized” and all that follows through “purpose” and inserting “may make grants to such States for the purpose”;

(3) in subsection (d), by striking “(B)” and inserting “(B)”.

(4) in subsection (g)(2), by striking “(B)” and inserting “(B)”.

SEC. 2526. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 317T the following:

“SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

“(a) Program.—To the extent and in the amount of appropriations made in advance in appropriations Acts, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program consisting of making grants, in amounts determined under subsection (c), to States for each State that submits an application in accordance with subsection (d) for an evidence-based education program described in subsection (b).

“(b) Use of Funds.—Amounts received by a State under this section shall be used to conduct or support evidence-based education programs (directly or through grants or contracts) to public or private nonprofit entities, including schools and community-based and faith-based organizations, to reduce teen pregnancy or sexually transmitted diseases.

“(c) Distribution of Funds.—The Director shall, for fiscal year 2011 and each subsequent fiscal year, make a grant under this section to each State submitted an application in accordance with subsection (d) in an amount equal to the product of—

“(1) the amount appropriated to carry out this section for the fiscal year; and

“(2) the percentage determined for the State under section 502(c)(1)(B)(i) of the Social Security Act.

“(d) Application.—To seek a grant under this section, a State shall submit an application at such time, in such manner, and containing such information and assurance of compliance as the Secretary may require. At a minimum, an application shall include the following:

“(1) a description of the State’s multiyear grant proposal, including a description of the evidence-based model that will be made available to the State;

“(2) the evidence-based model that will be made available to the State;

“(3) the evidence-based model that will be made available by the Secretary to the Secretary on such programs and the results of evaluation of such programs;

“(4) to delay initiation of sex;

“(5) to reduce number of partners;

“(6) to reduce sexually transmitted infection rates;

“(7) to improve rates of contraceptive use.

“(j) Authorization of Appropriations.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015.’’.

SEC. 2527. NATIONAL TRAINING INITIATIVES ON AUTISM SPECTRUM DISORDERS.

Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) is amended by adding at the end the following:

“Subtitle F—National Training Initiative on Autism Spectrum Disorders

“SEC. 171. NATIONAL TRAINING INITIATIVE.

“(a) Grants and Technical Assistance.—

“(1) GRANTS.—(A) In General.—The Secretary, in consultation with the Interagency Autism Coordinating Committee, shall award multiyear grants to eligible entities to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary and interagency training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

“(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for children and adults with autism;

“(ii) Developing model services and supports that demonstrate evidence-based practices.

“(ii) Developing model services and supports that demonstrate evidence-based practices.

“(iii) Developing systems and products that allow for the interoperability of data; training, services, treatments, and supports to be evaluated for fidelity of implementation.

“(iv) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

“(v) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, and service providers; and

“(vi) containing such other information and assurances as the Secretary may require.

“(b) Use of Funds.—A grant received under this subsection shall be used to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary and interagency training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

“(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for children and adults with autism;

“(ii) Developing model services and supports that demonstrate evidence-based practices.

“(iii) Developing systems and products that allow for the interoperability of data; training, services, treatments, and supports to be evaluated for fidelity of implementation.

“(iv) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

“(v) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, autism advocacy groups, and community-based service providers.

“(c) Application Requirements.—An entity that desires to receive a grant for a program under this subsection shall submit to the Secretary an application—

“(i) demonstrating that the entity has capacity to—

“(i) provide training and technical assistance in evidence-based practices to evaluate, and provide effective interventions, services, treatments, and supports to, children and adults with autism and their families;

“(ii) include individuals with autism and their families as part of the program to ensure that an individual- and family-centered approach is used;

“(i) share and disseminate materials and practices that are developed for, and evaluated to be effective in, the provision of training and technical assistance; and

“(i) providing assurances that the entity will—

“(i) train personnel under this subsection with an appropriate balance of interdisciplinary academic and community-based experiences; and

“(i) provide services to, or support for, individuals with disabilities Education Act, and the Elementary and Secondary Education Act of 1965; and

“(i) consistent with the goals of this Act, the Americans with Disabilities Act of 1990, the Individuals with Disabilities Education Act, and the Elementary and Secondary Education Act of 1965.

“(ii) to delay initiation of sex;

“(ii) to decrease number of partners;

“(ii) to reduce sexually transmitted infection rates;

“(ii) to improve rates of contraceptive use.

“(iv) Authorization of Appropriations.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015.’’.

November 7, 2009
‘(vi) Working to develop comprehensive systems of supports and services for individuals with autism and their families, including seamless transitions between education and health care and the lifelong care needed.

‘(vii) Promoting training, technical assistance, dissemination of information, supports, and services.

‘(viii) Developing mechanisms to provide training and technical assistance, including for-credit courses, intensive summer institutes, continuing education programs, distance-based programs, and Web-based information dissemination strategies.

‘(ix) Promoting activities that support community living and individual services and enable individuals with autism and related developmental disabilities to fully participate in society and achieve good quality of life.

‘(x) Collecting data on the outcomes of training and technical assistance programs to meet statewide needs for the expansion of services to children and adults with autism.

‘(E) AMOUNT OF GRANTS.—The amount of a grant to any entity for a fiscal year under this section shall be not less than $250,000.

‘(2) GRANTS.—To provide for the establishment of a network of national centers to:

‘(A) assist in national dissemination of specific information, including evidence-based training, interdisciplinary training programs, and when appropriate, other entities whose findings would inform the work performed by entities awarded grants;

‘(B) compile and disseminate strategies and materials that prove to be effective in the provision of training and technical assistance so that the entire network can benefit from the models, materials, and practices developed in individual centers;

‘(C) assist in the coordination of activities of grantees under this subsection;

‘(D) develop a Web portal that will provide linkages to each of the individual training initiatives and provide access to training modules, promising training, and technical assistance practices and other materials developed by grantees;

‘(E) develop a research-based resource for Federal and State policymakers on information concerning the provision of training and technical assistance for the assessment, and provision of support and services for, children and adults with autism;

‘(F) convene experts from multiple interdisciplinary training programs, individual services, and the families of such individuals to discuss and make recommendations with regard to training issues related to assessment, interventions, services, treatment, and supports for children and adults with autism; and)

‘(G) undertake any other functions that the Secretary determines to be appropriate.

‘(3) E LIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall:

‘(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (c);

‘(2) submit to the Secretary a plan for achieving long-term financial sustainability;

‘(3) where applicable, submit a plan for coordinating MTM services with other local providers and stakeholders, through or in collaboration with the Medicare Medical Home Pilot program as established by section 1866F of the Social Security Act, as added by section 1005(a) of this Act;

‘(4) submit a plan for accommodating the requirements under subsection (c); and

‘(5) submit to the Secretary such other information as the Secretary may require.

‘(4) MTM SERVICES TO TARGETED INDIVIDUALS.—(a) The MTM services provided under this subsection shall be as determined by the Secretary.

‘(b) The MTM services provided under this subsection shall include: (i) medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

‘(c) documenting the care delivered and communicating essential information about the care delivered to the pharmacist (referred to in this section as a medication review) and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

‘(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

‘(d) targeted individuals.—MTM services provided under grants awarded under subsection (a) shall be offered to targeted individuals who—

‘(1) take 4 or more prescribed medications (including over-the-counter and dietary supplements); (2) take any high-risk medications;

‘(3) have 2 or more chronic diseases, as identified by the Secretary;

‘(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems; and

‘(e) Consultation with experts.—In designing and implementing MTM services provided under grants awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacists, advocates, provincially and nationally, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacists delivering MTM services, and the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is appropriate to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

‘(d) TARGETED INDIVIDUALS.—MTM services provided under grants awarded under subsection (a) shall be offered to targeted individuals who—

‘(1) take 4 or more prescribed medications (including over-the-counter and dietary supplements); (2) take any high-risk medications;

‘(3) have 2 or more chronic diseases, as identified by the Secretary;

‘(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems; and

‘(e) Consultation with experts.—In designing and implementing MTM services provided under grants awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacists delivering MTM services, and the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is appropriate to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

‘(2) APPLICABLE PROVISIONS.—Except for subsection (a), the provisions of subsection (a) shall apply with respect to grants under this subsection to the same extent and in the same manner as such provisions apply with respect to grants under subsection (a).
lies about postpartum conditions to promote means; and
ments through television, radio, and other services for health professionals and the public, and diagnostic techniques.
ethnic groups with respect to the conditions. 
ations and the differences among racial and causes of the conditions.
funding the development of programs, including conducting and supporting the following:
the impact of patient-cost-sharing requirements on medication adherence and recommendations for modifications;
(5) identify and evaluate other factors that may influence health and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and
(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

(h) Grant to Fund Development of Performance Measures.—The Secretary may award grants or contracts to eligible entities for the purpose of developing the development of performance measures that assess the use and effectiveness of medication therapy management services.

SEC. 2529. Postpartum Depression.

(a) Expansion and intensification of activities.—The Secretary shall expand and intensify activities on postpartum conditions.

(2) Programs for Postpartum Conditions.—In carrying out paragraph (1), the Secretary may continue to conduct research to expand the understanding of the causes of, and treatments for, postpartum conditions, including conducting and supporting the following:

(1) Basic research concerning the etiology and causes of the conditions.

(b) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development of programs; and

(e) Information and education programs.

(G) Risky sexual behavior;

(D) Tobacco use;

(E) Alcohol and substance use;

(F) Injury and violence;

(G) Risky sexual behavior;

(H) Untreated mental health problems;

(I) Untreated dental and oral health problems; and

(J) Understanding informed consent;

(K) To educate and provide guidance regarding effective strategies to promote positive health behaviors within the family; and

(L) To educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

(1) Poor nutrition;

(2) Physical inactivity;

(3) Being overweight or obese;

(4) Cigarette use;

(5) Alcohol and substance use;

(6) Injury and violence;

(7) Risky sexual behavior;

(8) Untreated mental health problems;

(9) Untreated dental and oral health problems; and

(10) Understanding informed consent;

(L) To educate and provide guidance regarding effective strategies to promote positive health behaviors within the family; and

(M) To educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

(1) Poor nutrition;

(2) Physical inactivity;

(3) Being overweight or obese;

(4) Tobacco use;

(5) Alcohol and substance use;

(6) Injury and violence;

(7) Risky sexual behavior;

(8) Untreated mental health problems;

(9) Untreated dental and oral health problems; and

(10) Understanding informed consent;

(M) To educate and provide guidance regarding effective strategies to promote positive health behaviors within the family; and

(N) To educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

(1) Poor nutrition;

(2) Physical inactivity;

(3) Being overweight or obese;

(4) Tobacco use;

(5) Alcohol and substance use;

(6) Injury and violence;

(7) Risky sexual behavior;

(8) Untreated mental health problems;

(9) Untreated dental and oral health problems; and

(10) Understanding informed consent;

(N) To educate and provide guidance regarding effective strategies to promote positive health behaviors within the family; and

(O) To educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

(1) Poor nutrition;

(2) Physical inactivity;

(3) Being overweight or obese;

(4) Tobacco use;

(5) Alcohol and substance use;

(6) Injury and violence;

(7) Risky sexual behavior;

(8) Untreated mental health problems;

(9) Untreated dental and oral health problems; and

(10) Understanding informed consent;
health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such programs to provide care to patients who do not reside in the community in which the individual who promotes health or nutrition education resides.

"(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

"(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

"(i) REPORT TO CONGRESS.—

"(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

"(2) CONTENTS OF REPORT.—The report required under paragraph (1) shall include the following:

"(A) A description of the programs for which grant funds were used;

"(B) The number of individuals served under such programs;

"(C) An evaluation of—

"(i) the effectiveness of such programs;

"(ii) the impact of such programs; and

"(iii) the impact of the programs on the health outcomes of the community residents;

"(D) Recommendations for sustaining the community health worker programs developed or assisted under this section;

"(E) Recommendations regarding training to enhance career opportunities for community health workers.

"(k) DEFINITIONS.—In this section:

"(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides.

"(A) by serving as a liaison between communities and health care agencies;

"(B) by providing guidance and social assistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with health care providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health needs, including oral and mental, or nutrition needs; and

"(F) by providing referral and followup services or otherwise coordinating care.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant resides.

"(3) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State, United States territory or possession, or a consortium of any of such entities, located in the United States that—

"(A) has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

"(B) a significant portion of which is a health professional shortage area as designated under section 332.

"(4) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or private nonprofit entity, or a public subdivision of a State, a public health department, or a federally qualified health center, or a consortium of any of such entities, located in the United States or territory thereof.

"(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2011 through 2015.

SEC. 2531. MEDICAL LIABILITY ALTERNATIVES.

(a) INCENTIVE PAYMENTS FOR MEDICAL LIABILITY REFORM.—

"(1) IN GENERAL.—To the extent and in the amounts made available in advance in appropriations Acts, the Secretary shall make an incentive payment, in an amount determined by the Secretary, to each State that has an alternative medical liability law in compliance with this section.

"(2) DETERMINATION BY SECRETARY.—The Secretary shall determine that a State has an alternative medical liability law in compliance with this section if the Secretary is satisfied that—

"(A) the State enacted the law after the date of the enactment of this Act and is implementing the law;

"(B) the law is effective; and

"(C) the content of the law are in accordance with paragraph (4).

"(3) CONSIDERATIONS FOR DETERMINING EFFECTIVENESS.—In determining whether an alternative medical liability law is effective under paragraph (2)(B), the Secretary shall consider whether the law—

"(A) makes the medical liability system more reliable, predictable, or prompt and fair resolution of disputes;

"(B) encourages the disclosure of health care errors; and

"(C) maintains access to affordable liability insurance.

"(4) CONTENTS OF ALTERNATIVE MEDICAL LIABILITY LAW.—The contents of an alternative liability law are in accordance with this paragraph if—

"(A) the litigation alternatives contained in the law consist of certificate of merit, early offer, or both;

"(B) the law does not limit attorneys' fees or impose caps on damages;

"(C) no limitation on other state laws.—Nothing in this section shall be construed to—

"(1) preempt or modify the application of any existing State law that limits attorneys' fees or imposes caps on damages;

"(2) impair the authority of a State to establish or implement a law limiting attorneys' fees or imposing caps on damages; or

"(3) affect the eligibility of a State for an incentive payment under this section on the basis of a law described in subparagraph (A) or (B) so long as any such law is not established or implemented as part of the law described in paragraph (4), as determined by the Secretary.

"(5) USE OF INCENTIVE PAYMENTS.—Amounts received by a State as an incentive payment under this section shall be used to improve health care in that State.

"(6) INCENTIVE PAYMENTS.—The Secretary shall pay to the States applying for or receiving an incentive payment under this section.

"(d) REPORTS.—Beginning not later than one year after enactment of this Act, the Secretary shall submit to the Congress an annual report on the progress States have made in enacting and implementing alternative liability laws in compliance with this section. Such reports shall contain sufficient documentation regarding the effectiveness of such laws to enable an objective comparative analysis of such laws.

"(e) DEFINITION.—In this section—

"(1) the term "Secretary" means the Secretary of Health and Human Services; and

"(2) the term "State" includes the several States, District of Columbia, the Commonwealth of Puerto Rico, and each other territory of the United States.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, as may be necessary, to remain available until expended.

SEC. 2532. INFANT MORTALITY PILOT PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary"), acting through the Director, shall make grants to eligible entities proposing to serve any of the 15 counties or groups of counties with the highest rates of infant mortality in the United States in the past 3 years.

"(1) use of funds.—Infant mortality pilot program funded under this section may—

"(1) include the development of a plan that identifies the individual or groups of each community to be served and strategies to address those needs;

"(2) provide outreach to at-risk mothers through programs deemed appropriate by the Director;

"(3) develop and implement standardized systems for improved access, utilization, and insurance; and clinical services to promote healthy pregnancies, full term births, and healthy infants delivered to women and their infants, such as—

(A) counseling on infant care, feeding, and parenting;

(B) postpartum care;

(C) prevention of premature delivery; and

(D) additional counseling for at-risk mothers, including smoking cessation programs, drug treatment programs, alcohol treatment programs, nutrition and physical activity programs, postpartum depression and domestic violence programs, social and psychological services, dental care, and parenting programs;

(4) establish a rural outreach program to provide care to at-risk mothers in rural areas;

(5) establish a regional public health education campaign, including a campaign to—

(A) prevent preterm births; and

(B) educate the public about infant mortality; and

(6) provide for any other activities, programs, or strategies as identified by the community plan.

"(b) REPORT.—Of the funds received through a grant under this section for a fiscal year, an eligible entity shall not use more than 10 percent for program evaluation.

"(c) REPORTS ON PILOT PROGRAMS.—

"(1) IN GENERAL.—Not later than 1 year after receiving a grant, and annually thereafter to the extent that the entity that receives a grant under subsection (a) shall submit a report to the Secretary detailing its infant mortality pilot program.

"(2) CONTENTS OF REPORT.—The reports required under paragraph (1) shall include information such as the methodology of, and outcomes and statistics from, the grantee's infant mortality pilot program.

"(3) EVALUATION.—The Secretary shall use the reports required under paragraph (1) to...
H12774

CONGRESSIONAL RECORD — HOUSE
November 7, 2009

evaluate, and conduct statistical research on, infant mortality pilot programs funded through this section.

g. DEFINITIONS.—For the purposes of this section—

(i) DIRECTOR.—The term “Director” means the Director of the Centers for Disease Control and Prevention.

(ii) PROGRAMS.—The term “eligible entity” means a State, county, city, territorial, or tribal health department that has submitted a proposal to the Secretary that the Secretary deems likely to reduce infant mortality rates within the standard metropolitan statistical area involved.

(iii) TRIBAL.—The term “tribal” refers to an Indian tribe, band, or other group of Indians, including an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.

(iv) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for each of fiscal years 2011 through 2015.

SEC. 2533. SECONDARY SCHOOL HEALTH SCIENCES TRAINING PROGRAM.

(a) PROGRAM.—The Secretary of Health and Human Services, acting through the Administrator of Health Resources and Services Administration, and in consultation with the Secretary of Education, may establish a health sciences training program consisting of awarding grants and contracts under this section to prepare secondary school students for careers in health professions.

(b) DEVELOPMENT AND IMPLEMENTATION OF HEALTH SCIENCES CURRICULA.—The Secretary may make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, or implement secondary school health sciences curricula, including curricula in biology, chemistry, mathematics, nutrition, and other sciences deemed appropriate by the Secretary to prepare students for associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors; and

(2) to increase the interest of secondary school students in applying to, and enrolling in, accredited associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors, including through—

(A) work-study programs;

(B) provide increased awareness of careers in health professions; and

(C) other activities to increase such interest.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall—

(1) be a local educational agency; and

(2) provide assurances that activities under the grant or contract will be carried out in partnership with an accredited health professions school or program, public or private nonprofit hospital, or private or public nonprofit entity.

(d) PREFERENCE.—In awarding grants and contracts under subsection (b), the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Graduating a high or significantly improved percentage of students who have exhibited mastery in secondary school State science standards.

(2) Graduating students from disadvantaged populations, including racial and ethnic minorities who are underrepresented—

(A) associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors; or

(B) health professions.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2534. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

(a) PURPOSE.—The purpose of this subtitle is to establish and provide assistance to community-based collaborative care networks—

(1) to develop or strengthen coordination of services for the uninsured, the low-income, and chronically sick; and

(2) to reduce the use of emergency department services and the number of low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

(b) ELIGIBILITY AND GRANTEE SELECTION.—

(1) APPLICATION.—A community-based collaborative care network described in subsection (d) shall submit an application in such form and manner containing such information as specified by the Secretary. Such information shall at a minimum—

(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant including, if a provider designated in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

(B) include a description of how the proposed collaborative care network will increase comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

(C) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made and how the decision-making process of the network will include appropriate representation of the participating entities;

(D) define the geographic areas and populations that the network intends to serve;

(E) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3); and

(F) demonstrate the network’s ability to meet the requirements of this section; and

(2) SELECTION OF GRANTEES.—The Secretary may award grants to, or enter into contracts with, eligible entities that demonstrate an ability to meet the requirements of this section.

SEC. 3400. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

(a) IN GENERAL.—The Secretary may award grants to, or enter into contracts with, entities for the purpose of establishing model projects to accomplish the following goals:

(1) To reduce unnecessary use of items and services furnished in emergency departments of hospitals (especially to ensure that individuals without health insurance coverage or with inadequate health insurance coverage are served in a health department instead of the services of a primary care provider) through methods such as—

(A) screening individuals who seek emergency department services for possible eligibility under relevant governmental health programs or for subsidies under such programs; and

(B) providing such individuals referrals for followup care and chronic condition care.

(2) To manage chronic conditions to reduce their severity, negative health outcomes, and costs;

(3) To encourage health care providers to coordinate their efforts so that the most vulnerable patient populations seek and obtain primary care; and

(4) To provide more comprehensive and coordinated care to vulnerable low-income individuals and individuals without health insurance coverage or with inadequate coverage.

(b) PREFERENCE.—To provide for quality and efficiency of care for low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

(c) AUTHORIZATION OF APPROPRIATIONS.—(1) To increase preventive services, including screening and counseling, to those with low-income the decision-making process of the network will include appropriate representation of the participating entities; and

(2) To ensure the availability of community-wide safety net services, including emergency and trauma care.

(d) GRANT AND CONTRACT SELECTION.—(1) ELIGIBILITY AND GRANTEE SELECTION.—(A) APPLICATION.—A community-based collaborative care network described in subsection (d) shall submit an application in such form and manner containing such information as specified by the Secretary. Such information shall at a minimum—

(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant including, if a provider designated in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

(B) include a description of how the proposed collaborative care network will increase comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

(C) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made and how the decision-making process of the network will include appropriate representation of the participating entities; and

(D) define the geographic areas and populations that the network intends to serve;

(E) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3); and

(F) demonstrate the network’s ability to meet the requirements of this section; and

(G) define the geographic areas and populations that the network intends to serve;

(H) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3); and

(I) define the geographic areas and populations that the network intends to serve; and

(J) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3).

(b) SELECTION OF GRANTEES.—

(1) IN GENERAL.—The Secretary shall select community-based collaborative care networks to receive grants from applications submitted under paragraph (1) on the basis of quality of the proposal submitted, geographic diversity (including different States and regions served and urban and rural diversity), the number of low-income and uninsured individuals that the proposal intends to serve.

(2) PRIORITY.—The Secretary shall give priority to proposals from community-based collaborative care networks that—

(A) include the capability to provide the broadest range of services to low-income individuals; and

(B) include providers that currently serve a high volume of low-income individuals.

(c) RENEWAL.—In subsequent years, based on the quality of performance under paragraph (1), the Secretary may provide renewal grants to prior year grant recipients.

(d) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a
community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services. If such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

"(4) TERMINATION AUTHORITY.—The Secretary may terminate selection of a community-based collaborative care network under this subsection if such collaborative care network shall include a determination that the network—

(A) has failed to provide a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2); or

(B) has failed to meet reasonable quality standards;

(C) has misappropriated funds provided under this section for good cause.

"(5) USE OF FUNDS.—

(1) USE BY GRANTEES.—Grant funds are provided to community-based collaborative care networks to carry out the following activities:

(A) Assist low-income individuals without adequate health care coverage to—

(i) access and appropriately use health services;

(ii) enroll in applicable public or private health insurance programs;

(iii) obtain referrals to and see a primary care provider in case such an individual does not have a primary care provider; and

(iv) obtain appropriate care for chronic conditions.

(B) Improve health care by providing case management, application assistance, and appropriate referrals such as through methods to—

(i) create and meaningfully use a health information technology network to track patients across collaborative providers;

(ii) ensure health outreach, such as by using neighborhood health workers who may inform individuals about the availability of safety net and primary care providers available through the community-based collaborative care network;

(iii) provide for followup outreach to re- mind patients of appointments or follow-up care needs; and

(iv) provide transportation to individuals to and from the site of care;

(C) Expand the capacity to provide care at any provider participating in the community-based collaborative care network, including telehealth, hiring new clinical or administrative staff, providing access to services and resources, and otherwise providing an urgent care alternative to an emergency department; and

(D) provide a primary care provider or medication network patient.

(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration (in this section referred to as ‘HRSA’) or impose other requirements on HRSA grantees participating in a community-based collaborative care network as may be necessary for consistency with the requirements of such programs.

(3) RESERVATION OF FUNDS FOR NATIONAL PROGRESSIVE RANGE OF COORDINATED AND INTEGRATED HEALTH CARE SERVICES.—The Secretary shall define criteria for evaluating whether the services offered by a community-based collaborative care network qualify as a comprehensive range of coordinated and integrated health care services. Such criteria may vary based on the needs of the geographic areas and populations to be served by the network and may include the following:

(A) including community-based collaborative care networks to include at least the suggested core services identified under subsection (b)(3), or whichever subset of the suggested core services is applicable to a particular network.

(B) Requiring such networks to assign each patient of the network to a primary or other care provider responsible for managing that patient’s care.

(C) Requiring the services provided by a community-based collaborative care network to include support services appropriate to meet the health needs of low-income populations in the network’s community, which may include chronic care management, nutritional counseling, mental health care, language services, enrollment counselors, social services and other services as proposed by the network.

(D) Providing that the services provided by a community-based collaborative care network may also include long-term care services and other services not specified in this subsection.

(E) Providing for the approval by the Secretary of a scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals available in the community the network serves.

(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify the network provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to the services reimbursable under such title. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible under a contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

(4) EVALUATIONS.—

(A) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation on the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

(i) the number of people served;

(ii) the most common health problems treated;

(iii) any reductions in emergency department visits;

(iv) any improvements in access to primary care;

(B) an accounting of how amounts re- ceived are used, including identification of amounts used for patient care services as may be required for HRSA grantees; and
“(F) to the extent requested by the Secretary, any quality measures or any other measures specified by the Secretary.

(2) PROGRAM REPORTS.—The Secretary shall establish a mechanism for the submission of a periodical report to Congress, beginning not later than 6 months after the first report required under paragraph (1) is submitted, on the extent to which emergency departments of participating hospitals and such other providers have improved health outcomes and decreased health care utilization and costs resulting from improvements to, the entity’s program funded under the grant or contract, and on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratio described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

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

(1) The terms ‘elementary school’, ‘local educational agency’, and ‘secondary school’ have the meanings given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term ‘eligible local educational agency’ means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students per nurse.

(3) The term ‘high-need local educational agency’ means a local educational agency—

(A) that serves not fewer than 10,000 children in the United States.

(B) for which not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

SEC. 2538. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education shall make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies to demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the entity, in part by giving preference on current ratios of students to school nurses.

(b) MOUNTING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(c) REPORT.—Not later than 30 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(4) The term ‘nurse’ means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2537. MEDICAL LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish and carry out a pilot program to enhance the service provided by legal service providers to low-income individuals and families with a history of working with entities that have a history of working with in and serving the community.

(b) DEFINITIONS.—In this section:

(1) The term ‘evidence-based’ means that methodology used in the research has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children’s Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

(2) The term ‘local educational agency’ has the meaning given to that term in section 9101 of the Elementary and Secondary Education Act of 1965.

(3) The term ‘prevention of overweight and obesity in its community, including the extent of the problem and factors contributing to the problem.

(4) The term ‘evidence-based’ means that methodology used in the research has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children’s Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

(2) The term ‘local educational agency’ has the meaning given to that term in section 9101 of the Elementary and Secondary Education Act of 1965.

(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

SEC. 2538. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education shall make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies to demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the entity, in part by giving preference on current ratios of students to school nurses.

(b) MOUNTING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(c) REPORT.—Not later than 30 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(4) The term ‘nurse’ means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2537. MEDICAL LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish and carry out a pilot program to enhance the service provided by legal service providers to low-income individuals and families with a history of working with entities that have a history of working with in and serving the community.

(b) DEFINITIONS.—In this section:

(1) The term ‘evidence-based’ means that methodology used in the research has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children’s Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

(2) The term ‘local educational agency’ has the meaning given to that term in section 9101 of the Elementary and Secondary Education Act of 1965.

(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

SEC. 2538. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education shall make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies to demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the entity, in part by giving preference on current ratios of students to school nurses.

(b) MOUNTING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(c) REPORT.—Not later than 30 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(4) The term ‘nurse’ means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2537. MEDICAL LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish and carry out a pilot program to enhance the service provided by legal service providers to low-income individuals and families with a history of working with entities that have a history of working with in and serving the community.
(1) awarding grants to, and entering into contracts with, medical-legal partnerships to assist patients and their families to navigate health-related programs and activities; and
(2) evaluating the effectiveness of such partnerships.
(b) Use of Funds.—Amounts received as a grant or contract under this section shall be used to—(1) establish and maintain a medical-legal partnership; and (2) provide services for individuals in primary health care settings.
(1) to provide medical health and substance abuse screening, brief interventions, referral, and recovery services;
(2) to carry out these services with primary health care services in the same program and setting;
(3) to develop a network of facilities to which patients may be referred if needed;
(4) to purchase needed screening and other tools that are—
(A) necessary for providing these services; and
(B) supported by evidence-based research; and
(5) to maintain communication with appropriate State mental health and substance abuse agencies.
(c) Eligibility.—To be eligible for a grant or contract, or cooperative agreement under this section, an entity shall be a public or private nonprofit entity that—
(1) provides services within the terms and purpose of this section;
(2) seeks to integrate mental health and substance abuse services into its service system;
(3) has developed a working relationship with providers of mental health and substance abuse services; and
(4) demonstrates a need for the inclusion of mental health and substance abuse services in its service system; and
(5) agrees—
(A) to prepare and submit to the Secretary, in a format prescribed by the Secretary, an annual report to the Congress on the results of the demonstration project under this section. Such report shall include the following:
(i) the extent to which medical-legal partnerships funded through this section achieved the goals described in subsection (b); and
(ii) recommendations on the possibility of extending or expanding the demonstration project.

SEC. 2538. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.
Part D of title V (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

SEC. 544. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.
(a) Program.—The Secretary, acting through the Administrator, shall establish a program of awarding grants, contracts, and cooperative agreements under subsection (b) on mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary health care settings.

(b) Use of Funds.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, entities to—
(1) provide medical health and substance abuse screening, brief interventions, referral, and recovery services;

SEC. 2539. GRANTS TO ASSIST IN DEVELOPING MEDICAL SCHOOLS IN FEDERALLY DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS.
(a) Grants Authorized.—The Secretary of Health and Human Services may make grants to nonprofit organizations or institutions of higher education for the purpose of assisting the organization or institution involved to develop a medical school if—
(1) the medical school will be located in an area that is designated under section 332 of the Public Health Service Act (42 U.S.C. 205(e)) as a health professional shortage area; and
(2) the organization or institution provides assurances satisfactory to the Secretary of substantial public or private funding from non-Federal sources for the development of the medical school; and
(3) the organization or institution provides assurances satisfactory to the Secretary that accreditation will be achieved for the medical school.

(b) Use of Grant Funds.—Grants awarded under this section may be used for the acquisition and building of the medical school campus in a health professional shortage area and the purchase of equipment, curriculum and faculty development, and general operations related to the development and establishment of the medical school.

(c) Authorization of Appropriations.—For the purpose of carrying out this section, there is authorized to be appropriated $100,000,000 for each of fiscal years 2011 through 2015.

PART 3—EMERGENCY CARE-RELATED PROGRAMS
SEC. 2551. TRAUMA CARE CENTERS.
(a) Grants for Trauma Care Centers.—Section 1241 (42 U.S.C. 300d–41) is amended to read as follows:

SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.
(a) In General.—The Secretary shall establish a trauma center program consisting of awarding grants under section (b).

(b) Grants.—The Secretary shall award grants as follows:

(1) Existing Centers.—Grants to public, private nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers—
(A) to further the core missions of such centers; or
(B) to provide emergency relief to ensure the continued and future availability of trauma services by trauma centers—
(i) at risk of closing or operating in an area where a closing has occurred within their primary service area; or
(ii) in need of financial assistance following a natural disaster or other catastrophic event, such as a terrorist attack.

(2) New Centers.—Grants to local governments and public or private nonprofit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes.

(c) Minimum Qualifications of Trauma Centers.

(1) Participation in Trauma Care System Operating Under Certain Professional Guidelines.

(2) Designation.—Subject to subparagraph (B), the Secretary may not award a grant to an existing trauma center under this section if the center is a participant in a trauma care system that substantially complies with section 1213.

(B) Exemption.—Subparagraph (A) shall not apply to trauma centers that are located in States with no existing trauma care system.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.
(a) In General.—The Secretary shall establish a trauma center program consisting of awarding grants under section (b).

(b) Grants.—The Secretary shall award grants as follows:

(1) Existing Centers.—Grants to public, private nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers—
(A) to further the core missions of such centers; or
(B) to provide emergency relief to ensure the continued and future availability of trauma services by trauma centers—
(i) at risk of closing or operating in an area where a closing has occurred within their primary service area; or
(ii) in need of financial assistance following a natural disaster or other catastrophic event, such as a terrorist attack.

(2) New Centers.—Grants to local governments and public or private nonprofit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes.

(c) Minimum Qualifications of Trauma Centers.

(1) Participation in Trauma Care System Operating Under Certain Professional Guidelines.

(2) Designation.—Subject to subparagraph (B), the Secretary may not award a grant to an existing trauma center under this section if the center is a participant in a trauma care system that substantially complies with section 1213.

(B) Exemption.—Subparagraph (A) shall not apply to trauma centers that are located in States with no existing trauma care system.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center is a participant in a trauma care system that substantially complies with section 1213.
“(B) designated as a trauma center by the applicable State health or emergency medical services authority.”.

(b) Considerations in Making Grants.—Section 1241(b) of such Act (42 U.S.C. 300d–42) is amended to read as follows:

**SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.**

(a) Core Mission Awards.—

(1) In General.—In awarding grants under section 1241(b)(1)(A), the Secretary shall—

(A) maintain a minimum of 25 percent of the amount allocated for such grants for level III and level IV trauma centers in rural or underserved areas;

(B) observe a minimum of 25 percent of the amount allocated for such grants for level I and level II trauma centers in urban areas;

(C) give preference to any application made by a trauma center—

(i) in a geographic area where growth in demand for trauma services exceeds capacity;

(ii) that demonstrates the financial support of the State or political subdivision involved;

(iii) that at least 1 graduate medical education fellowship in trauma or trauma-related specialties, including neurological surgical professional care, vascular surgery, and spinal cord injury, for which demand is exceeding supply; or

(iv) that demonstrates a substantial commitment to serving vulnerable populations.

(2) Financial Support.—For purposes of paragraph (1)(C)(iii), financial support may be demonstrated by State or political subdivision funding for the trauma center’s capital or operating expenses (including through State trauma regional advisory coordination activities, Medicaid funding designated for trauma centers, or other governmental funding). State funding derived from Federal support shall not constitute State or local financial support for purposes of preferential treatment under this subsection.

(c) Use of Funds.—The recipient of a grant under section 1241(b)(1)(A) shall carry out, consistent with furthering the core mission of the center, one or more of the following activities:

(1) Providing 24-hour-a-day, 7-day-a-week trauma care availability.

(2) Reducing overcrowding related to throughput of trauma patients.

(3) Enhancing trauma surge capacity.

(4) Ensuring physician and essential personnel availability.

(5) Trauma education and outreach.

(6) Coordination with local and regional trauma care systems.

(7) Such other activities as the Secretary may deem appropriate.

(d) Emergency Awards; New Centers.—In awarding grants under paragraphs (1)(B) and (2) of section 1241(b), the Secretary shall—

(1) give preference to any application submitted by a center that demonstrates the financial support (in accordance with subsection (a)(2)) of the State or political subdivision involved for the activities to be funded through the grant for each fiscal year during which payments are made to the center under the grant; and

(2) give preference to any application submitted for a trauma center that—

(A) is providing or will provide trauma care in a geographic area in which the availability of trauma care has either significantly decreased or is projected to result in the closure of a trauma center in the area permanently ceasing participation in a system described in section 1241(c)(1) as of a date occurring during the 2-year period before the fiscal year for which the trauma center is applying to receive a grant, or in geographic areas where growth in demand for trauma services exceeds capacity;

(B) will, in providing trauma care during the 1-year period beginning on the date on which the application is submitted, incur substantial uncompensated care costs in an amount that renders the center unable to continue participation in such system as a result of a significant decrease in the availability of trauma care in the geographic area;

(C) operates or will operate in rural areas where trauma availability may significantly decrease if the center is forced to close or downgrade service and substantial costs are contributing to a likelihood of such closure or downgrade;

(D) is in a geographic location substantially affected by a natural disaster or other catastrophic event such as a terrorist attack; or

(E) will establish a new trauma service in an urban area with a substantial degree of trauma resulting from violent crimes.

(2) Designations of Levels of Trauma Centers in Certain States.—In the case of a State which has not designated 4 levels of trauma centers, any reference in this section to—

(1) a level I or level II trauma center is deemed to be a reference to a trauma center within the highest 2 levels of trauma centers designated under paragraphs (1)(B) and (2) of section 1241; and

(2) a level III or IV trauma center is deemed to be a reference to a trauma center not within such highest 2 levels.

(f) Certain Agreements.—Section 1243 (42 U.S.C. 300d–43) is amended to read as follows:

**SEC. 1243. CERTAIN AGREEMENTS.**

(a) Commitment Regarding Continued Participation in the System.—The Secretary may not award a grant to an applicant under section 1241(b) unless the applicant agrees that—

(1) the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

(2) if the agreement made pursuant to paragraph (1) is violated by the center, the Secretary shall—

(A) terminate the grant or portion of the grant that is causing the center to be unable to meet the terms of the agreement; and

(B) may reassign performance of the core mission activities to another entity.

(b) Limitation on Duration of Support.—The period during which a trauma center receives payments under a grant under section 1241(b)(1) shall be for 3 fiscal years, except that the Secretary may waive such requirement for the center and authorize the center to receive such payments for 1 additional fiscal year.

(c) Eligibility.—The acquisition of, or eligibility for, a grant under section 1241(b) shall not preclude a trauma center’s eligibility for another grant described in such section.

(d) Funding Distribution.—Of the total amount appropriated for a fiscal year under section 1245—

(1) 90 percent shall be used for grants under paragraph (1)(A) of section 1241(b); and

(2) 10 percent shall be used for grants under paragraphs (1)(B) and (2) of section 1241(b) for the trauma centers authorized to be expended, the Secretary shall reallocate for grants under section 1241(b), but not obligated due to insufficient applications for such grants.

(e) Authorization of Appropriations.—Section 1245 (42 U.S.C. 300d–45) is amended to read as follows:

**SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.**

(a) General.—For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2011, and such sums as may be necessary for each of the 5 fiscal years following fiscal year 2011.

(b) Reallotment.—The Secretary shall reallocate for grants under section 1241(b)(1)(A) any funds appropriated for grants under paragraph (1)(B) or (2) of section 1241(b), but not obligated due to insufficient applications eligible for funding.

**SEC. 2552. EMERGENCY CARE COORDINATION CENTER.**

(a) In General.—Subtitle B of title XXVIII of the Health Care for America Act, and every 2 years thereafter, the Secretary shall biennially—

(1) report to Congress on the status of the grants made pursuant to section 1241(b); and

(2) evaluate and report to Congress on the overall financial stability of trauma centers in the United States;

(3) report on the populations using trauma care centers and include aggregate patient data on income, race, ethnicity, and geography; and

(4) evaluate the effectiveness and efficiency of trauma care center activities using standard public health measures and evaluation methodologies.

(b) Authorization of Appropriations.—Section 1245 (42 U.S.C. 300d–45) is amended to read as follows:

**SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.**

(a) General.—For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2011, and such sums as may be necessary for each of the 5 fiscal years following fiscal year 2011.

(b) Reallotment.—The Secretary shall reallocate for grants under section 1241(b)(1)(A) any funds appropriated for grants under paragraph (1)(B) or (2) of section 1241(b), but not obligated due to insufficient applications eligible for funding.

**SEC. 2552. EMERGENCY CARE COORDINATION CENTER.**

(a) In General.—Subtitle B of title XXVIII (42 U.S.C. 300h–10 et seq.) is amended by adding at the end the following:

**SEC. 2554. EMERGENCY CARE COORDINATION CENTER.**

(1) Establishment.—The Secretary shall establish, within the Office of the Assistant Secretary for Preparedness and Response, an Emergency Care Coordination Center (in this section referred to as the ‘‘Center’’), to be headed by a director.

(ii) The Secretary, acting through the Director of the Center, in coordination with the Federal Interagency
Committee on Emergency Medical Services, shall—

(A) promote and fund research in emergency medicine and trauma health care;

(B) establish partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and

(C) promote local, regional, and State emergency medical systems’ preparedness for and response to public health events.

(b) COUNCIL OF EMERGENCY CARE.—

(1) ESTABLISHMENT.—The Secretary, acting through the Director of the Center, shall establish a Council of Emergency Care to provide advice and recommendations to the Director on carrying out this section.

(2) COMPOSITION.—The Council shall be comprised of representatives of the departments and agencies of the Federal Government who are experts in emergency care and management.

(c) REPORT.—

(1) SUBMISSION.—Not later than 12 months after the date of the enactment of the Affordable Health Care for America Act, the Secretary shall submit to the Congress an annual report on the activities carried out under this section.

(2) CONSIDERATIONS.—In preparing a report under paragraph (1), the Secretary shall consider factors including—

(A) emergency department crowding and boarding; and

(B) delays in care following presentation.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

(b) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Emergency Medical Coordinating Center, as in existence on the day before the date of the enactment of this Act, shall be transferred to the Emergency Care Coordination Center established under section 315(a) of the Public Health Service Act, as added by subsection (a).

SEC. 2553. PILOT PROGRAMS TO IMPROVE EMERGENCY MEDICAL CARE.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR EMERGENCY CARE RESPONSE.

(a) In General.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

(b) ELIGIBLE ENTITY; REGION.—

(1) ELIGIBLE ENTITY.—In this section, the term ‘eligible entity’ means a State or a similar entity that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

(c) DEMONSTRATION PROGRAM.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes to be an appropriate program that may be designed, implemented, and evaluated an emergency medical system that—

(1) coordinates with public safety services, primary and secondary healthcare facilities, medical services, medical facilities, and other entities within a region;

(2) coordinates an approach to emergency medical system access throughout the region, including 9–1–1 public safety answering points and emergency medical dispatch;

(3) includes provisions for Federal, State, and regional and local emergency medical system access, including an interregional communications network, that operates throughout the region to ensure that the correct patient is taken to the medically appropriate facility (whether an initial facility or a higher level facility) in a timely fashion;

(4) allows for the tracking of prehospital and hospital resources, including impatient care bed capacity, emergency department capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with communications and hospital destination decisions; and

(5) includes a consistent regionwide prehospital, hospital, and interfacility data management system that—

(A) complies with the National EMS Information System, the National Trauma Data Bank, and others;

(B) reports data to appropriate Federal and State databanks and registries; and

(C) contains information sufficient to evaluate key elements of prehospital care, hospital placement, including regional hospital and interfacility decisions, and relevant outcomes of hospital care.

(d) APPLICATION.—

(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that the proposed approach—

(i) has been coordinated with the applicable State office of emergency medical services (or equivalent State office);

(ii) is compatible with the applicable State emergency medical services system;

(iii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

(iv) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

(v) includes a categorization or designation system for special medical facilities throughout the region that—

(I) consistent with State laws and regulations; and

(II) integrated with the protocols for transport and destination throughout the region;

(vi) includes a regional medical direction system, a patient tracking system, and a resource allocation system that—

(I) supports day-to-day emergency care system operation;

(II) can manage surge capacity during a major event or disaster; and

(III) is integrated with other components of the national and State emergency preparedness system;

(B) an agreement to make available non-Federal contributions in accordance with subsection (e); and

(C) such other information as the Secretary may require.

(e) MATCHING FUNDS.—

(1) IN GENERAL.—With respect to the costs of the activities to be carried out each year, the Secretary shall reserve 25 percent of such costs in an amount that is not less than 25 percent of such costs.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services, the value of which has been involved in the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(f) PRIORITY.—The Secretary shall give priority to the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved population (as defined in section 330(b)(3)).

(g) REPORT.—Not later than 90 days after the completion of a demonstration program under subsection (a), the recipient of such contract or grant described in such subsection shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

(1) the impact of the regional, accountable emergency care system on patient outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, and pediatric emergencies;

(2) the system characteristics that contribute to the effectiveness and efficiency of the program or lack thereof;

(3) methods of assuring the long-term financial sustainability of the emergency care system;

(4) the State and local legislation necessary to implement and to maintain the system; and

(5) the barriers to developing regionalized, accountable emergency care systems, as well as the methods to overcome such barriers.

(h) EVALUATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall enter into a contract with an academic institution or other entity to conduct an independent evaluation of the demonstration programs funded under subsection (a), including an evaluation of—

(1) the performance of the eligible entities receiving the funds; and

(2) the impact of the demonstration programs.

(i) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, report to the public and to the appropriate committees of the Congress, the information contained in a report made under subsection (b).

(j) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $12,000,000 for each of fiscal years 2011 through 2015.

(2) RESERVATION.—Of the amount appropriated to carry out this section for a fiscal year, the Secretary shall reserve 3 percent of the amount to carry out subsection (b) (relating to an independent evaluation).
SEC. 2556. DENTAL EMERGENCY RESPONDERS: DENTAL EMERGENCY RESPONSE.

(a) NATIONAL HEALTH SECURITY STRATEGY.—Section 2502(b)(3) (42 U.S.C. 300hh–20(b)(3)) is amended—

(3) by inserting "public health and medical" after "medical'' after "medical''.

(b) ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RESEARCH COMMITTEE.—The Secretary for purposes of section 516(c) of the Homeland Security Act of 2002 (6 U.S.C. 101) is amended—

(1) in the matter preceding subparagraph (A), by striking "public health and medical" after "medical"; and

(2) in paragraph (A), by inserting "and dental'' after "medical''.

(c) ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RESPONSE CURRICULA AND TRAINING.—Section 319A(a)(5)(B) (42 U.S.C. 247d–6(a)(5)(B)) is amended by striking "public health or medical" and inserting "public health, medical, or dental''.

SEC. 2556. DENTAL EMERGENCY RESPONDERS: HOMELAND SECURITY.

(a) NATIONAL RESPONSE FRAMEWORK.—Paragraph (6) of section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101) is amended by inserting "and dental'' after "emergency medical technicians''.

(b) NATIONAL PREPAREDNESS SYSTEM.—Subparagraph (B) of section 653(b)(4) of the Post-Katrina Emergency Management Reform Act of 2006 (6 U.S.C. 753(b)(4)) is amended by striking "public health and medical'' and inserting "public health, medical, and dental''.

(c) CHIEF MEDICAL OFFICER.—Paragraph (5) of section 516(c) of the Homeland Security Act of 2002 (6 U.S.C. 516(c)) is amended by striking "medical community'' and inserting "medical and dental communities''.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

SEC. 2561. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.

(a) CONVENEING.—Not later than June 30, 2011, the Institute of Medicine and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this section referred to as "the Conference").

(b) PURPOSE.—The purposes of the Conference shall be—

(1) increase the recognition of pain as a significant public health problem in the United States;

(2) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(3) identify barriers to appropriate pain care, including—

(A) lack of understanding and education among employers, patients, health care providers, regulators, and payers;

(B) barriers to access to care at the primary, specialty, and tertiary care levels, including barriers—

(i) specific to those populations that are disproportionately untreated for pain;

(ii) related to physician concerns over regulatory and public health policy concerning pain medications; and

(iii) attributable to benefit, coverage, and payment policies in both the public and private sectors; and

(C) gaps in basic and clinical research on the symptoms and causes of pain, and potential assessment methods and new treatments to improve pain care; and

(4) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care delivery, education, and clinical care in the United States.

(c) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under subsection (a), the Secretary may enter into such an agreement with the Committee established under this section.

(d) REPORT.—The Comptroller General of the United States shall—

(1) conduct a study on the barriers experienced by veterans who received training as emergency medical technicians as follows:

(A) training; or

(B) applying for licensure or certification.

(2) expedite the licensing or certification process.

(e) ELIGIBILITY.—To be eligible for a grant under this section, a State shall demonstrate to the Secretary's satisfaction that the State is in shortage of emergency medical technicians.

(f) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

(h) GAO STUDY AND REPORT.—The Comptroller General of the United States shall—

(1) in the matter preceding subparagraph (A), by striking "public health and medical'' and inserting "medical'' after "medical''.

(i) P URPOSES.—The purposes of the Conference shall be—

(1) conduct a study on the barriers experienced by veterans who received training as emergency medical technicians as follows:

(A) training; or

(B) applying for licensure or certification.

(2) expedite the licensing or certification process.

(3) identify barriers to appropriate pain care, including—

(A) lack of understanding and education among employers, patients, health care providers, regulators, and payers;

(B) barriers to access to care at the primary, specialty, and tertiary care levels, including barriers—

(i) specific to those populations that are disproportionately untreated for pain;

(ii) related to physician concerns over regulatory and public health policy concerning pain medications; and

(iii) attributable to benefit, coverage, and payment policies in both the public and private sectors; and

(C) gaps in basic and clinical research on the symptoms and causes of pain, and potential assessment methods and new treatments to improve pain care; and

(4) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care delivery, education, and clinical care in the United States.

SEC. 2562. PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.

(a) RESEARCH INITIATIVES.—

(1) IN GENERAL.—The Director of NIH is authorized to initiate and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Prevention Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

(3) DUTIES.—The term ‘Pain Consortium’ means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of enactment of this section a similar trans-National Institutes of Health and other Federal agencies that relate to pain research.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Committee shall be composed of the following voting members:

(i) Not more than 7 voting Federal representatives as follows:

(1) The Director of the Centers for Disease Control and Prevention.

(2) The Director of the National Institutes of Health and the directors of such national research institutes and national centers as the Secretary determines appropriate.

(3) The heads of such other agencies of the Department of Health and Human Services as the Secretary determines appropriate.

(4) Representatives of other Federal agencies that conduct or support pain care research and treatment, including the Department of Defense and the Department of Veterans Affairs.

(ii) Twelve additional voting members appointed under subparagraph (B).

(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

(i) Six members shall be appointed from among such scientists, physicians, and other health professionals, who—

(I) are not officers or employees of the United States; and

(II) represent multiple disciplines, including clinical, basic, and public health sciences;

(ii) represent different geographical regions of the United States; and

(iii) are from practice settings, academia, manufacturers, or other research settings.

(iii) The Committee shall meet not later than 1 year after the date of the enactment of this section and as necessary duplication of effort;

(iv) The Committee shall meet at least annually, the Pain Consortium, in consultation with the Division of Prevention Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH, but in no case less often than once each year.

(v) DUTIES.—The Committee shall—

(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies, including the Department of Defense and the Department of Veterans Affairs, are free of unnecessary duplication of effort; and

(D) make recommendations on how best to disseminate information on pain care; and

SEC. 2563. ENFORCEMENT.

(a) PROHIBITION ON FINANCIAL SUPPORT.—Nothing in this section shall be construed to authorize Federal funds to be used to support research on pain in which prisoners are subjects except pursuant to a protocol approved by the United States Food and Drug Administration.

(b) P FRAMING AND ADMINISTRATION.—The Director of NIH, but in no case less often than once each year.
SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

Part B of title II (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

"SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

(a) Establishment.—Not later than 12 months after the date of the enactment of this section, the Secretary shall establish and implement a national pain care education and awareness campaign designed to educate the general public about the diagnosis, treatment, and management of pain, particularly chronic pain, and the related economic, societal, and financial consequences of pain. The Secretary shall ensure the involvement in the public awareness campaign under this section of consumers, patients, their families, and other caregivers with respect to—

"(1) the incidence and importance of pain as a national public health problem;

"(2) the adverse physical, psychological, emotional, societal, and financial consequences that can result if pain is not appropriately assessed, diagnosed, treated, or managed;

"(3) the availability, benefits, and risks of all pain treatment and management options;

"(4) having pain promptly assessed, appropriately diagnosed, treated, and managed, and regularly reassessed with treatment adjusted as needed;

"(5) the role of credentialed pain management specialists and subspecialists, and of comprehensive interdisciplinary centers of treatment, in the care of pain patients;

"(6) the availability in the public, non-profit, and private sectors of pain management-related information, services, and resources for consumers, employers, third-party payors, patients, their families, and caregivers, including information on—

"(A) appropriate assessment, diagnosis, treatment, and management options for all types of pain and pain-related symptoms; and

"(B) conditions for which no treatment options are currently underserved; and

"(7) other issues the Secretary deems appropriate.

(c) Consultation.—In designing and implementing the public awareness campaign required by this section, the Secretary shall consult with organizations representing patients in pain and other consumers, employers, physicians including physicians specializing in pain care, other pain management professionals, medical device manufacturers, and pharmaceutical companies.

(d) Coordination.—

"(1) Lead official.—The Secretary shall designate one official in the Department of Health and Human Services to coordinate the campaign established under this section.

"(2) Agency coordination.—The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

"(e) Underserved areas and populations.—In designing the public awareness campaign under this section, the Secretary shall—

"(1) take into account the special needs of geographic areas and racial, ethnic, gender, age, and other demographic groups that are currently underserved; and

"(2) provide resources that will reduce disparities in access to appropriate diagnosis, assessment, and treatment.

(f) Grants and contracts.—The Secretary shall enter into agreements, cooperative agreements, and contracts with public agencies and private nonprofit organizations to assist with the development and implementation of the public awareness campaign under this section.

(g) Evaluation and report.—Not later than the end of fiscal year 2012, the Secretary shall prepare and submit to the Congress a report that evaluates the effectiveness of the public awareness campaign under this section in educating the general public with respect to the matters described in subsection (b).

(h) Authorization of Appropriations.—For purposes of carrying out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 and 2013.

Subtitle C—Food and Drug Administration

PART 1—IN GENERAL

SEC. 2571. NATIONAL MEDICAL DEVICE REGISTRY.

(a) Registry.—

"(1) In general.—Section 519 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is amended by—

"(A) redesignating subsection (g) as subsection (h); and

"(B) by inserting after subsection (i) the following:

"(g) Medical Device Registry .—

"(i) National Medical Device Registry .—The Secretary shall establish a national medical device registry (in this subsection referred to as the "registry") to facilitate analysis of postmarket safety and outcomes data for covered devices.

"(B) In this subsection, the term 'covered device' means—

"(i) shall include each class III device; and

"(ii) may include, as the Secretary determines appropriate and specifies in regulation, a class II device that is life-supporting or life-sustaining.

"(C) Notwithstanding subparagraph (B)(i), the Secretary may by order exempt a class III device from the provisions of this subsection if the Secretary concludes that inclusion of information on the device in the registry will not provide useful information on safety or effectiveness.

"(2) In developing the registry, the Secretary shall, in consultation with the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Agency for Healthcare Research and Quality, the head of the Office of the National Coordinator for Health Information Technology, and the Secretary of Veterans Affairs, determine the best methods for—

"(A) including in the registry, in a manner consistent with subsection (f), appropriate information respecting a covered device by type, model, and serial number or other unique identifier;

"(B) validating methods for analyzing patient safety and outcomes data from multiple sources and for linking such data with the information included in the registry as described in subparagraph (A), including, to the extent feasible, use of—

"(i) data provided to the Secretary under other provisions of this chapter; and

"(ii) information from public and private sources identified under paragraph (3); and

"(C) integrating the activities described in this subsection (so as to avoid duplication) with—

"(i) activities under paragraph (3) of section 506(k) (relating to active postmarket risk identification); and

"(ii) activities under paragraph (4) of section 506(k) (relating to advanced analysis of drug safety data); and

"(iii) other postmarket device surveillance activities of the Secretary authorized by this chapter; and

"(iv) registries carried out by or for the Agency for Healthcare Research and Quality; and

"(D) providing public access to the data and analysis collected or developed through the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

"(D) make recommendations on how to expand partnerships between public entities, including Federal agencies, and private entities to expand collaborative, crosscutting research efforts.

"(2) Requirements.—The Secretary shall design the public awareness campaign under this section to educate consumers, patients, their families, and other caregivers with respect to—

"(1) the incidence and importance of pain as a national public health problem;

"(2) the adverse physical, psychological, emotional, societal, and financial consequences that can result if pain is not appropriately assessed, diagnosed, treated, or managed;

"(3) the availability, benefits, and risks of all pain treatment and management options;

"(4) having pain promptly assessed, appropriately diagnosed, treated, and managed, and regularly reassessed with treatment adjusted as needed;

"(5) the role of credentialed pain management specialists and subspecialists, and of comprehensive interdisciplinary centers of treatment, in the care of pain patients;

"(6) the availability in the public, non-profit, and private sectors of pain management-related information, services, and resources for consumers, employers, third-party payors, patients, their families, and caregivers, including information on—

"(A) appropriate assessment, diagnosis, treatment, and management options for all types of pain and pain-related symptoms; and

"(B) conditions for which no treatment options are currently underserved; and

"(7) other issues the Secretary deems appropriate.

(c) Consultation.—In designing and implementing the public awareness campaign required by this section, the Secretary shall consult with organizations representing patients in pain and other consumers, employers, physicians including physicians specializing in pain care, other pain management professionals, medical device manufacturers, and pharmaceutical companies.

(d) Coordination.—

"(1) Lead official.—The Secretary shall designate one official in the Department of Health and Human Services to coordinate the campaign established under this section.

"(2) Agency coordination.—The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

"(e) Underserved areas and populations.—In designing the public awareness campaign under this section, the Secretary shall—

"(1) take into account the special needs of geographic areas and racial, ethnic, gender, age, and other demographic groups that are currently underserved; and

"(2) provide resources that will reduce disparities in access to appropriate diagnosis, assessment, and treatment.

"(f) Grants and contracts.—The Secretary shall enter into agreements, cooperative agreements, and contracts with public agencies and private nonprofit organizations to assist with the development and implementation of the public awareness campaign under this section.

"(g) Evaluation and report.—Not later than the end of fiscal year 2012, the Secretary shall prepare and submit to the Congress a report evaluating the effectiveness of the public awareness campaign under this section in educating the general public with respect to the matters described in subsection (b).

"(h) Authorization of Appropriations.—For purposes of carrying out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 and 2013."
and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

"(5)(A) The Secretary shall promulgate final regulations under paragraph (4) not later than 36 months after the date of the enactment of this subsection.

"(B) Before the notice of proposed rulemaking preceding the final regulations described in subparagraph (A), the Secretary shall hold a public hearing before an advisory committee on the issue of which class II devices to include in the definition of covered device.

"(C) The Secretary shall include in any regulation under this subsection an explanation demonstrating that the requirements of such regulation—

"(i) do not duplicate other Federal requirements; and

"(ii) do not impose an undue burden on device manufacturers.

"(6) With respect to any entity that submits or is required to submit a safety report or other information in connection with the safety of a device under this section (and any release by the Secretary of that report or information), such report or information shall not be construed to reflect necessarily a conclusion by the entity or the Secretary that the report or information constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or otherwise caused or contributed to injury, illness, or death. Such an entity need not admit, and may deny, that the report or information submitted by the entity constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or caused or contributed to a death, serious injury, or serious illness.

"(7) Any person who is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 and 2012:

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall establish and begin implementation of the registry under section 519(g) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), by not later than the date that is 36 months after the date of the enactment of this Act, without regard to whether or not final or temporary regulations under such section are promulgated by such date.

(3) CONFORMING AMENDMENT.—Section 303(c)(1)(B)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333(c)(1)(B)(ii)) is amended by striking "519(g)" and inserting "519(h).

(4) ELECTRONIC EXCHANGE AND USE OF CERTIFIED ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDENTIFIERS.—

(1) RECOMMENDATIONS.—The HIT Policy Committee established under section 3002 of the Public Health Service Act (42 U.S.C. 300j–12) shall recommend to the head of the Office of the National Coordinator for Health Information Technology standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device (as defined under section 519(g)(3)(B) of the Federal Food, Drug, and Cosmetic Act, as added by subparagraph (A)) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1).

(2) STANDARDS, IMPLEMENTATION CRITERIA, AND CERTIFICATION CRITERIA.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall adopt standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device referred to in paragraph (1), if such an identifier is required by section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) for the device.

(3) UNIFORM CERTIFICATION SYSTEM.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall develop final regulations to implement section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) not later than 6 months after the date of the enactment of this Act.

(4) SEC. 2572. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS AND VENDING MACHINES.—

(a) TYPICAL MENU ITEMS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

"(1) in subsection (b), by striking "except as provided in clause (H)(iii)," after "(i)"; and

"(2) in subsection (b), by inserting "except as provided in clauses (ii)(III) and (vi)," after "(i)".

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

"(II) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

"(1) GENERALS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subsection (vii), in the case of food that is a standard menu item, for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the nutrient information as described in subclauses (i) and (iii).

"(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

"(aa) the nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the menu items that come in different flavors, presentations, or customary market test appearing on the menu for less than 60 days or other items placed on the table or counter (such as condiments and beverage chasers) to examine the Nutrition Facts Panel of this clause, a restaurant or similar retail food establishment shall have a reasonable opportunity to examine, in the context of a total daily diet, the significance of the caloric intake information that is provided on the menu;

"(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu;

"(cc) the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(dd) the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(e) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

(1) SELF-SERVICE FOOD AND FOOD ON DISPENSERS.—In the case of a vending machine, the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous disclosure of the number of calories contained in the article.

(1) UNAUTHORISED PROVISION OF NUTRITION INFORMATION.—

"(a) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

"(b) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

"(c) such other food that is part of a custom market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

(2) WRITTEN FORM.—Clause (C) shall apply to any regulation promulgated under subclauses (i)(ii) and (vi).

(2) VENDING MACHINES.—In the case of an article of food sold from a vending machine that—

"(i) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

"(ii) is operated by a person who is engaged in the business of owning or operating vending machines, the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous disclosure of the number of calories contained in the article.

(2) UNAUTHORISED PROVISION OF NUTRITION INFORMATION.—

"(a) In general.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not complying with the requirements of such a clause may elect to be subject to the requirements of such clause, by registering biannually the
name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

(II) REGULATIONS.—Within 120 days of the enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementing program described in paragraph (I), pending promulgation of regulations.

(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

(II) CONTENTS.—In promulgating regulations, the Secretary shall—

(aa) Consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food employees, and ingredients, and other factors, as the Secretary determines; and

(bb) Specify the format and manner of the nutrition content disclosure requirements under this subclause.

(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward implementing final regulations under this subparagraph.

(x) DEFINITION.—In this clause, the term ‘menu’ or ‘menu board’ means the primary writing, sign, or display regarding the food and is the subject of the patent infringement claim in which—

(i) an ANDA filer receives anything of value; and

(ii) the ANDA filer agrees to limit or forego research, development, manufacturing, marketing, or sales, for any period of time, of the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim.

(B) EXCEPTIONS.—Notwithstanding subparagraph (A)(i), subparagraph (A) does not prohibit a resolution or settlement of a patent infringement claim in which the value received by the ANDA filer includes no more than—

(i) the right to market the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim, before the expiration of—

(A) the patent that is the basis for the patent infringement claim; or

(B) any other statutory exclusivity that would prevent the marketing of such drug; and

(ii) the waiver of a patent infringement claim for damages based on prior marketing of such drug.

(C) ENFORCEMENT.—(1) DUTIES.—A violation of subparagraph (A) shall be treated as an unfair and deceptive act or practice and an unfair method of competition in or affecting interstate commerce prohibited under section 5 of the Federal Trade Commission Act and shall be enforced by the Federal Trade Commission in the same manner, by the same means, and with the same jurisdiction as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this subsection.

(ii) INAPPLICABILITY.—Subchapter A of chapter VII shall not apply with respect to the submission.

(IV) DEFINITIONS.—In this subsection:

(i) AGREEMENT.—The term ‘agreement’ means anything that would constitute an agreement under section 5 of the Federal Trade Commission Act.

(ii) AGREEMENT RESOLVING OR SETTLING.—The term ‘agreement resolving or settling’, in reference to a patent infringement claim, includes any agreement that is contingent upon, provides a contingent condition for, or is otherwise related to the resolution or settlement of the claim.

(iii) ANDA.—The term ‘ANDA’ means an abbreviated new drug application for the approval of a new drug under section (i).

(iv) ANDA FILER.—The term ‘ ANDA filer’ means a party that has filed an ANDA with the Food and Drug Administration.

(v) PATENT INFRINGEMENT.—The term ‘patent infringement’ means the infringement of any patent or of any filed patent application, extension, reissue, renewal, division, continuation, continuation-in-part, reexamination, patent term restoration, patent of addition, or extension thereof.

(vi) PATENT INFRINGEMENT CLAIM.—The term ‘patent infringement claim’ means any allegation made to an ANDA filer, whether or not included in a complaint filed with a court of law, that its ANDA or drug to be manufactured under such ANDA may infringe any patent.

(vii) 2 FTC RULEMAKING.—The Federal Trade Commission may, by rule promulgated under section 553 of title 5, United States Code, adopt certain agreements described in paragraph (1) from the requirements of this subsection if the Commission finds such agreements to be in furtherance of market competition and for the benefit of consumers. Consistent with the authority of the Commission, such rules may include interpretive rules and general statements of policy with respect to the practices prohibited under paragraph (1).

(viii) NOTICE AND CERTIFICATION OF AGREEMENTS.—(1) NOTICE OF ALL AGREEMENTS.—Section 1122(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (2 U.S.C. 3515 note) is amended—

(A) striking the Commission the and inserting the following: ‘the Commission—’;

(B) striking the period at the end and inserting ‘; and’; and

(C) adding at the end the following:

(2) CERTIFICATION OF AGREEMENTS.—Section 1112 of such Act is amended by adding at the end the following:

(d) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under subsection (a) shall execute and file with the Assistant Attorney General and the Commission a certification under oath or by perjury that the following is true and correct:

(1) The materials filed with the Federal Trade Commission and the Department of Justice under section 1122 of title XI of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, with
BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) not withstanding any other law, agreements filed under section 1112 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1397cc), or other agreements, shall be disclosed to the Comptroller General for purposes of the study under paragraph (1) within 30 days of a request by the Comptroller General.

PART 2—BIOSIMILARS

251. LICENSURE PATHWAY FOR BIO-
SIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (l)(4) by inserting “under this subsection or subsection (k)” after “biologics license” and

(b) by adding at the end the following:

“(k) LEGAL STANDARDS APPLICABLE TO BIOLOGICAL PRODUCTS MANUFACTURED IN FOREIGN COUNTRIES—A biological product, in an application for licensure of a biological product, shall be manufactured in a foreign country only to the extent the mechanism or mechanisms of action of the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product.

(III) the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling of the biological product have been previously approved for the reference product;

(IV) the route of administration, the dosage form, and strength of the biological product are the same as those of the reference product; and

(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

(II) DETERMINATION BY SECRETARY—The Secretary may determine, in the Secretary’s discretion, that an element described in clause (I) is unnecessary in an application submitted under this subsection.

(III) ADDITIONAL INFORMATION—An application submitted under this subsection—

(A) shall include publicly available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

(B) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

(III) INTERCHANGEABILITY—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

(IV) EVALUATION BY SECRETARY—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

(A) the Secretary determines that the information submitted in the application (or supplement) is sufficient to show that the biological product—

(i) is biosimilar to the reference product; or

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) the applicant that submitted such application has provided the information in submission of the application under this subsection.

(IV) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable for the reference product if the Secretary determines that the information submitted in the application (or supplement to such application) is sufficient to show that—

(A) the biological product—

(i) is biosimilar to the reference product; and

(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using either the reference product without such alternation or switch.

(IV) GENERAL RULES—

(A) ONE BIOLOGICAL PRODUCT PER APPLICATION—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

(B) REVIEW—An application submitted under this subsection shall be reviewed by the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

(C) EVALUATION STRATEGIES—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (k).

(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS—If information in an application submitted under this subsection, in a supplement to an application, or otherwise available to the Secretary shows that a biological product—

(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.37 of title 42, or section 353.3 of title 7, Code of Federal Regulations (or any successor regulations); or

(ii) is, bears, contains, or holds meets standards designed to assure that the biological product continues to be safe, pure, and potent.

(E) EXCLUSIVITY FOR INTERCHANGEABLE BIOLOGICAL PRODUCT—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary may not make a determination under paragraph (i) that the subsequent biological product is interchangeable for any condition of use until the earlier of—

(A) 1 year after the first commercial marketing of the first approved biosimilar biological product to be approved as interchangeable for that reference product; or

(B) 18 months after—

(i) a final court decision on all patents in suit in an action instituted under subsection (1)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) the dismissal with or without prejudice of an action instituted under subsection (1)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (1)(5) and such litigation is still ongoing within such 42-month period; or

(C) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (1)(5) and such litigation is still ongoing within such 42-month period; or

(D) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (1)(5).

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

(7) EXCLUSIVITY FOR REFERENCE PRODUCT—
after the date on which the interested third party provides the list required by clause (ii), the interested third party shall identify that patent within 30 days of the date of issue of the list in accordance with the procedures established in accordance with the processes established in accordance with the procedures established in accordance with the procedures established in accordance with the procedures established in accordance with the procedures established in paragraph (4) or under paragraph (9) (ii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (i) or under subparagraph (ii) of subparagraph (B), the applicant shall send a written notice to the Secretary and the Federal Trade Commission not later than—

(i) 10 business days after the date on which the application is filed; and

(ii) prior to the date of the first commercial marketing of, or for agreements described in subparagraph (C)(ii), any biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of the application described in such subparagraph.

(b) FILING.—

(i) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of the application described in such subparagraph.

(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under this subsection shall—

(A) certify in writing that the agreement or agreement described in subsection (k)(4), means that the biological product is highly interchangeable with the reference product and has requested the Secretary to not grant the application as follows: 'I declare under penalty of perjury that the biological product is highly interchangeable with the reference product and

(B) subject matter of agreement.—An agreement described in this subparagraph—

(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or the interested third party under paragraph (9) (ii) or (iv) of subparagraph (B), the reference product sponsor or by a use of the biosimilar product in treatment that is indicated in the application; and

(iii) may specify whether the relevant patent is available for licensing; and

(iv) provide a detailed written explanation setting forth the reasons why the applicant believes—

(A) the making, use, sale, or offer for sale within the United States, or importation into the United States, or the use of the biosimilar product that is the subject of the application in a treatment indicated in the application, would not infringe the patent; or

(B) the patent is invalid or unenforceable.

(C) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent is brought by the reference product sponsor under paragraph (9) (ii) of subparagraph (B), or by an interested third party under clause (i) or (ii) subparagraph (B), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed by the court, the approval of the application shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product and the reference product sponsor, or any agreement between bio-

(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this subsection (k) and the reference product sponsoring committee or subcommittee of the Congress. and has requested the Secretary to not grant the application, and the Federal Trade Commission not later than—

(ii) prior to the date of the first commercial marketing of, or for agreements described in subparagraph (C)(ii), any biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of the application described in such subparagraph.

(iii) if agreement not reduced to text.—If an agreement required to be filed by subparagraph (A)(i) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under this subsection shall—

(A) certify in writing that the agreement or agreement described in subsection (k)(4), means that the biological product is highly interchangeable with the reference product and

(iii) certification.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under subparagraph (B), the applicant and the court in which such action has been commenced the patent is infringed prior to the date applicable under subsection (k), the Secretary shall make approval of the approval on the day after the date of expiration of thepatent that has been found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

(ii) notification of agreements.—

(A) REQUIREMENTS.—

(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT SPONSOR AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and the sponsor shall each file the agreement in accordance with subparagraph (C).

(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If more than one biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into any agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

(8) Subject matter of agreement.—An agreement described in this subparagraph—

(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or any agreement between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of a biological product that is shown to meet the standards of safety, purity, and potency of the product.

(E) ENFORCEMENT.—

(i) CIVIL PENALTY.—Any person that violates any provision of this paragraph shall be liable for a civil penalty of not more than $1,000 for each day a violation occurs. Such penalty may be recovered in a civil action.

(ii) brought by the United States, or

(iii) brought by the Federal Trade Commission in accordance with the procedures established in this section 553 of the Federal Trade Commission Act.

(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

(i) may define the terms used in this paragraph; and

(ii) may exempt classes of persons or agreements from the requirements of this paragraph, and prescribe other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

(g) APPLICANTS.—If any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition law.

(b) Definitions.—Section 553(1) of the Public Health Service Act (42 U.S.C. 262(1)) is amended—

(1) by striking ‘‘In this section, the term ‘biological product’ means’’ and inserting ‘‘In this section, the term ‘biological product’ means—’’;

(2) in paragraph (1), as so designated, by inserting ‘‘(A) that the biological product is highly interchangeable with the reference product and

(3) by adding at the end the following:

The term ‘biological product’ means—

(C) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

H12786  CONGRESSIONAL RECORD — HOUSE  November 7, 2009
(1) **Requirement to Follow Section 351.**—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) **Exception.**—An application for a biological product may be submitted under section 356 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under section 356, not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the "Secretary") before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) **Limitation.**—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 356 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) **Deemed Approved Under Section 351.**—An approved application for a biological product under section 356 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) **Definitions.**—For purposes of this subsection, the term "biological product" has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

**SEC. 2576. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.**

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting "including licensure of a biological product under section 356(k) of such Act" before the period at the end.

**SEC. 2577. AMENDMENTS TO CERTAIN PATENT PROVISIONS.**

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking "or" after "patent";

(2) in subparagraph (B), by adding "or" after the comma at the end;

(3) by inserting the following after subparagraph (B):

"(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act;"; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: ", or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent;"

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking "in paragraph (2)" in both places it appears and inserting "in paragraph (2)(A) or (2)(B)".

**Subtitle D—Community Living Assistance Services and Supports**

**SEC. 2581. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY-LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS PROGRAM).**

(a) **ESTABLISHMENT OF CLASS PROGRAM.**—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 2303, is amended by adding at the end the following:

"**TITLE XXI—COMMUNITY-LIVING ASSISTANCE SERVICES AND SUPPORTS**

**SEC. 2301. PURPOSE.**—The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

(2) establish an infrastructure that will help address the Nation’s community living assistance services and supports needs;

(3) alleviate burdens on family caregivers; and

(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

**SEC. 2302. DEFINITIONS.**—In this title:

(1) **ACTIVE ENROLLEE.**—The term ‘active enrollee’ means an individual who is enrolled in the CLASS program in accordance with section 2304 and who has paid any premiums due to maintain such enrollment.

(2) **ACTIVELY EMPLOYED.**—The term ‘actively employed’ means an individual who—

(A) is reporting for work at the individual’s usual place of employment at any location to which the individual is required to travel because of the individual’s employment or (in the case of an individual who is a member of the uniformed services, on active duty and is physically able to perform the duties of the individual’s position); and

(B) is able to perform all the usual and customary duties of the individual’s employment on the individual’s regular work schedule.

(3) **ACTIVITIES OF DAILY LIVING.**—The term ‘activities of daily living’ has the meaning given such term in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986.

(4) **CLASS PROGRAM.**—The term ‘CLASS program’ means the program established under this title.

(5) **ELIGIBILITY ASSESSMENT SYSTEM.**—The term ‘eligibility assessment system’ means the system for each State established under this title.

(6) **ELIGIBILITY DETERMINATION.**—The term ‘eligibility determination’ means the determination made under such system.

(7) **MEDICAID.**—The term ‘Medicaid’ has the meaning given such term in section 1315 of the Social Security Act.

(8) **CLASS INDEPENDENCE ADVISORY COUNCIL.**—The term ‘CLASS Independence Advisory Council’ means the council established under section 2307(a).

(9) **CLASS INDEPENDENCE BENEFIT PLAN.**—The term ‘CLASS Independence Benefit Plan’ means the benefit plan developed and established by the Secretary in accordance with section 2303.

(10) **CLASS INDEPENDENCE FUND.**—The term ‘CLASS Independence Fund’ or ‘Fund’ means the fund established under section 2306.

(11) **MEDICARE.**—The term ‘Medicare’ has the meaning given such term in section 1812 of the Social Security Act.

(12) **PROTECTION AND ADVOCACY SYSTEM.**—The term ‘Protection and Advocacy System’ means the system for each State established under section 2307(b).

(13) **SEC. 2583. NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY-LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS PROGRAM).**

(a) **CLASS PROGRAM.**—The term ‘CLASS program’ means the program established under this title.

(b) **Eligible Beneficiary.**—The term ‘eligible beneficiary’ means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

(1) has paid premiums for enrollment in such program for at least 60 months;

(2) has earned, for each calendar year that occurs during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the minimum wages and self-employment income which an individual may earn with a quarter of coverage under section 213(d) of the Social Security Act for that year; and

(3) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual’s enrollment and ends on the date of such determination.

(b) **Date Described.**—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 2303(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

(c) **Regulations.**—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

**SEC. 2584. NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY-LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS PROGRAM).**

(a) **Process for Development.**—

(1) **In General.**—The Secretary, in consultation with appropriate authorities and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan for which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in this title consistent with the following requirements:

(A) **Premiums.**—Beginning with the first year of the CLASS program, and for each year thereafter, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period. The premiums paid by enrollees shall generate at least 21 consecutive payments for a continuous period of more than 90 days.

(B) **Vesting Period.**—A 5-year vesting period for eligibility for benefits.

(C) **Benefit Triggers.**—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

(i) The individual is determined to be unable to perform at least the minimum number of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

(ii) The individual requires substantial supervision to protect the individual from
threats to health and safety due to substantial cognitive impairment. 

(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

(D) Cash benefit.—Payment of a cash benefit that satisfies the following requirements:

(1) Minimum required amount.—The benefit amount provides an eligible beneficiary with a monthly benefit equal to average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at each benefit level).

(2) Amount scaled to functional ability.—The benefit amount is based on a scale of functional ability, with not less than a 2, and not more than 6, benefit level amounts.

(D) Daily or weekly.—The benefit is paid on a daily or weekly basis.

(E) No lifetime or aggregate limit.—The benefit is not subject to any lifetime or aggregate limit.

(2) Review and recommendation by the CLASS Independence Advisory Council.—The CLASS Independence Advisory Council shall:

(A) evaluate the alternative benefit plans developed under paragraph (1); and

(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines provides the adequate and benefits to meet enrollees’ needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

(3) Designation by the Secretary.—Not later than October 1, 2012, the Secretary, taking into account the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

(b) Additional premium requirements.

(1) Adjustment of premiums.—

(A) except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual’s enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

(B) Recalculated premium if required for program solvency.—

(i) in general.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, or other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individual enrollees in the CLASS program as necessary.

(ii) Exemption from increase.—Any increase in a monthly premium imposed as a result of the provision described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

(1) has attained age 65;

(2) to the premiums for enrollment in the program for at least 20 years; and

(III) is not actively employed.

(2) Recalculated premium if enrollment after more than a 3-month lapse.—

(i) in general.—The reenrollment of an individual after a 90-day period during which the CLASS program required to pay the monthly premium required to maintain the individual’s enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusted premium.

(ii) Credit for prior months if re-enrolled within 5 years.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month that the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the program shall be—

(A) credited with any months of paid premiums that accrued prior to the individual’s lapse in enrollment; and

(B) notwithstanding the total amount of any such credited months, required to satisfy section 3202(d)(A)(ii) before being eligible to receive benefits.

(iii) Penalty for premium after 5-year lapse.—If an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required to be age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by an amount of

(A) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the CLASS program and ends with the month preceding the month in which the re-enrollment is effective; or

(B) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

(2) Administrative expenses.—In determining the monthly premiums for the CLASS program, the Secretary may factor in costs for administering the program, not to exceed—

(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during such year; and

(B) of the premiums paid in subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

(3) No underwriting requirements.—No underwriting (other than on the basis of age in accordance with paragraph (2)) shall be used to—

(A) determine the monthly premium for enrollment in the CLASS program; or

(B) prevent an individual from enrolling in the program.

SEC. 2204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

(1) Automatic enrollment.—

(A) in general.—Subject to paragraph (2), the Secretary shall establish procedures under which each individual described in subsection (c) shall be automatically enrolled in the CLASS program by an employer of such individual under rules similar to the rules of sections 401(k)(13) and 414(w) of the Internal Revenue Code of 1986.

(B) Alternative payment mechanism.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

(A) who is self-employed;

(B) who has more than 1 employer;

(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary; or

(D) whose employer is not subject to automatic enrollment.

(2) Administration.—The Secretary shall, by regulation, establish procedures to—

(A) ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer and

(B) allow for an individual’s employer to deduct a premium for a spouse described in subsection (c)(2)(B) who is subject to automatic enrollment.

(3) Form.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

(4) Election to opt-out.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary shall prescribe.

(5) Individual described.—For purposes of enrollment in the CLASS program, an individual described in this paragraph is—

(A) who has attained age 18;

(B) who receives wages on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986;

(C) who is actively employed; and

(D) who is not—

(i) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

(ii) confined in a jail, prison, other penal institution or correctional facility, or by conviction of a criminal offense or in connection with a verdict or finding described in section 202(c)(1)(A)(ii) of the Social Security Act; or

(2) those who are not described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

(2) Rule of construction.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraphs (B) or (C) of subsection (a) in order to maintain enrollment in the CLASS program.

(1) Payroll deduction.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages of such individual in accordance with such procedures as the Secretary shall establish for employers who elect to deduct and withhold premiums on behalf of enrolled employees.

(2) Alternative payment mechanism.—The Secretary shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program who does not have an employer who elects to deduct and withhold premiums in accordance with subsection (A).

(3) Transfer of premiums collected.—

(A) in general.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during the preceding calendar year.

(B) Transfers based on estimates.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of...
the amounts collected in accordance with this section. Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were exceeded, or were less than, actual amounts collected.

"(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary shall establish procedures under which—

"(1) an individual who, in the year of the individual’s initial eligibility to enroll in the CLASS Independence Benefit Plan, without a licensed health care practitioner’s determination to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretary shall establish, only during an annual disenrollment period established by the Secretary that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

"(2) an individual shall only be permitted to disenroll from the program during an annual disenrollment period established by the Secretary and in such form and manner as the Secretary shall establish.

"SEC. 3205. BENEFITS.

"(a) DETERMINATION OF ELIGIBILITY.—

"(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for benefits under the CLASS Independence Benefit Plan.

"(2) ELIGIBILITY ASSESSMENTS.—

"(A) IN GENERAL.—Not later than January 1, 2013, the Secretary shall—

"(i) designate an entity (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to which, the entity is required to make quarterly determinations for purposes of title II or XVI of the Social Security Act) to serve as an Eligibility Assessment System by providing for the endorsement of active enrollees who apply for receipt of benefits;

"(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

"(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

"(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expe- dited process for an eligible beneficiary to determine eligibility, to require that—

"(i) the applicable dishonor procedures be completed within 14 days after submission of an appeal and the decision be made available within 45 days after submission of the appeal;

"(ii) in the event of a decision to grant coverage, the State shall enter into an agreement with a licensed practitioner, including, in any circumstances, the professional will be able to provide such services to a beneficiary who is not yet a beneficiary of the program, and the determination of eligibility by the professional will be made within 14 days of receipt of the request for services; and

"(iii) the decision to deny coverage will be made within 14 days of receipt of the request for services.

"(C) ELECTRONIC MANAGEMENT OF FUNDS.—In this clause, the term "electronic management of funds" means—

"(i) using technology to manage and disburse funds to beneficiaries;

"(ii) allowing the beneficiary to access such account through debit cards; and

"(iii) accounting for withdrawals by the beneficiary through electronic transfers to an account established by the beneficiary on his or her own or another resident’s choice.

"(d) ADMINISTRATIVE EXPENSES.—Advocacy services and advice and assistance counseling services provided by the Eligibility Assessment System under subsection (c) of this section shall be included as administrative expenses under section 3300.

"(e) LIFE INDEPENDENCE ACCOUNT.—

"(A) IN GENERAL.—The Secretary shall estab- lish procedures for administering the pro- vision of cash benefits to beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

"(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase medical services and products, home care services, and other services and products that may be necessary for the maintenance of the beneficiary in a community living arrangement of his or her choice.

"(f) ELIMINATION OF DEBT.—Nothing in this section shall prevent an eligible beneficiary from receiving medical assistance under Medicaid for home and community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable) for the remainder of any costs incurred in providing such assistance.

"(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a bene-

"(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term "home and community-based services" means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act, or the State plan amendment under subsection (i) of such sections.

"(IV) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

"(A) IN GENERAL.—Subject to subclause (I), if a beneficiary is receiving medical assist- ance under Medicaid for PACE program services under section 1915 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act or under a State plan amendment under subsection (i) of such section, the Secretary shall—

"(I) eliminate secondary coverage for the remain- der of any costs incurred in providing such assistance;

"(II) INSTITUTIONALIZED RECIPENTS OF PACE PROGRAM SERVICES.—In the event a beneficiary enrolling in the PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (I).

"(III) BENEFICIARY REPRESENTATIVES.—

"(A) IN GENERAL.—The Secretary shall estab- lish procedures to allow access to a bene- ficiary’s cash benefits by an authorized rep- resentative for the beneficiary on whose behalf such benefits are paid.

"(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under clause (A) shall en- sure that authorized representatives of eligi- ble beneficiaries comply with standards of

"(C) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a bene-
(A) information regarding how to access the appeals process established for the program; (B) assistance with respect to the annual recertification of eligibility, including an notification required under subsection (c)(6); and (C) such other assistance with obtaining services as the Secretary, by regulation, shall require.

3. The Secretary— (a) shall establish procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary; and (b) shall require the Protection and Advocacy System for a State, or any other Federally funded program, that provides services and supports in the most integrated setting to— (1) be held for investment on behalf of individuals enrolled in the CLASS program; (2) pay the administrative expenses related to the Fund and investment under subsection (b); and (3) pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

SEC. 3208. CLASS INDEPENDENCE FUND.

(a) Establishment of CLASS Independence Fund.—There is established in the Treasury of the United States a trust fund to be known as the ‘‘CLASS Independence Fund’. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(i)(II) and, remaining after investment of such amounts under subsection (c), including any reversion of any income derived from such investments. The amounts held in the Fund are appropriated and remain available without fiscal year limitation.

(1) to be held for investment on behalf of individuals enrolled in the CLASS program; (2) to pay the administrative expenses related to the Fund and investment under subsection (b); and (3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

SEC. 3209. CLASS ADVISORY BOARD.

(a) Establishment of Class Advisory Board.—There is hereby created a body to be known as the Class Advisory Board of the CLASS Independence Fund (hereinafter in this section referred to as the ‘‘Board’’). The Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, and the Federal Supplemental Medical Insurance Trust Fund may be represented and managed under subsections (c), (d), and (e) of section 1811(d) of the Social Security Act.

(b) Membership.—The Board shall consist of 4 members of the public, (one of whom may be from the same political party), each of whom shall be nominated and confirmed by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such individual’s term until the expiration of the time at which the member’s successor takes office. The Board shall be composed of 3 members (one of whom may be from the same political party). The Board may be called by the Secretary of the Treasury and shall be composed of 3 members (one of whom may be from the same political party). The Board shall be composed of 3 members (one of whom may be from the same political party). The Board is composed of 3 members (one of whom may be from the same political party). The Board of Trustees shall meet not less frequently than once each calendar year. The Board shall have the power to make all such rules and regulations as may be necessary to carry out the purposes of this Act.

(2) to pay the administrative expenses related to the Fund and investment under subsection (b); and (3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.
“(A) In General.—It shall be the duty of the Board of Trustees to do the following:

(i) Hold the CLASS Independence Fund.

(ii) Report to the Congress not later than the first day of each fiscal year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

(iii) Report immediately to the Congress whenever the Board of Trustees determines that the CLASS Independence Fund is not actuarially sound in regards to the projections under section 3203(b)(1)(B)(i).

(iv) General policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

(B) Report.—The report provided for in subparagraph (A)(ii) shall—

(i) include—

(1) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

(2) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year and each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

(IV) an actuarial opinion certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

(ii) be printed as a House document of the session of the Congress to which the report is made.

(C) Recommendations.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projections under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determines to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

SEC. 2307. CLASS INDEPENDENCE ADVISORY COUNCIL.

(a) Establishment.—There is hereby created an Advisory Committee to be known as the ‘CLASS Independence Advisory Council’.

(b) Membership.—

(i) In General.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care insurance, family health, and appropriate funding required to address
neglected diseases of poverty, including neglected parasitic diseases identified as Chagas disease, cysticercosis, toxocariasis, toxoplasmosis, trichomoniasis, the soil-transmitted helminths, and others. The report should provide the information necessary to enhance health policy to accurately evaluate and address the threat of these diseases.

SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

(a) ESTABLISHMENT.—Part A of title II (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research and health care, professional education, for issues of particular concern to women throughout their lifespan;

(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

(5) establish a National Women's Health Information Center to—

(A) facilitate the exchange of information regarding women's health, including health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

(B) facilitate access to such information;

(C) assist in the analysis of issues and problems relating to the matters described in this paragraph, and

(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

(6) develop and implement policies and programs to promote women's health programs and policies with the private sector; and

(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under this Act, and between the Office and health professionals and the general public;

(b) GRANTS AND CONTRACTS REGARDING DUTIES.—

(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, or other arrangements with, public and private entities, agencies, and organizations.

(2) EVALUATION AND DISSEMINATION.—The Secretary shall, directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out by the Federal financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

(3) REPORT.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare an appropriate report to the appropriate committees of Congress describing the activities carried out under this section during the period for which the report is being prepared.

"(e) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of the Director of the Department of Health and Human Services (established under section 229 of the Public Health Service Act, as added by this section) shall be deemed to be a reference to the Office on Women's Health in the Office of the Secretary.

"(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date;

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

shall be carried out by the Secretary or such other person, persons, or entity or entities as the Secretary determines.

The Secretary shall submit to the appropriate committees of Congress a report describing the activities carried out under this section during the effective period.

"(f) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all racial and social groups, means diseases, disorders, and conditions that—

(1) unique to, significantly more serious for, or significantly more prevalent in women; and

(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

"(g) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) (42 U.S.C. 267a(d)) is amended by inserting "and who shall report directly to the Director" before the period at the end of paragraph (1)."
other individuals and groups, as appropriate, on Agency policy with regard to women; and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4))."

and

(3) by adding at the end of section 928 (as redesignated by paragraph (1)) the following:

"(e) The Food and Drug Administration shall—

(i) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the "Food and Drug Administration") studies regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across age, biological, and sociocultural contexts;

(ii) establish short-range and long-range goals and objectives within the Administration that relate to health care providers training, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

(iii) provide information to women and health care providers on issues in which differences between men and women exist;

(iv) consult with pharmaceutical, biologic, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

(v) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

(vi) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)) of the Public Health Service Act.

SEC. 2589. LONG-TERM CARE AND FAMILY CARE-GIVER SUPPORT.

(a) AMENDMENTS TO THE OLDIER AMERICANS ACT OF 1965.—

(1) PROMOTION OF DIRECT CARE WORKFORCE. —Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 302(b)(1)) is amended by inserting before the semicolon the following: ";

and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and of assisting States in developing a comprehensive State workforce development plan with respect to such workforce, including assisting efforts to systematically assess, track, and report on workforce adequacy and capacity.

(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL. —Section 292 of such Act (42 U.S.C. 302) is amended by adding at the end the following:

"(g)(1) Not later than 90 days after the date of the enactment of this subsection, the Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel to examine and formulate recommendations on—

(A) working conditions and training for workers providing long-term services and supports, including home health aides, certified nurse aides, and personal care attendants; and

(B) other workforce issues related to such workers, including with respect to the adequacy of the number of such workers; the selection and training of such workers; and access to the services provided by such workers.

(2) The Panel shall include representatives of—

(A) relevant home- and community-based service providers, health care agencies, and facilities (including personal or home care agencies, long-term care and assisted living homes, assisted living facilities, and residential care facilities);
(B) the disability community, including individuals with disabilities and family caregivers;
(C) the nursing community;
(D) direct care workers (which may include union members and national organizations);
(E) other individuals, including senior individuals and family caregivers;
(F) State and Federal health care entities; and
(G) experts in workforce development and adult learning.

(3) Within 1 year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary and the Congress on workforce issues related to providing long-term services and supports, including information on core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources. 

(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 States to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

(5) Within 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILIES CAREGIVER SUPPORT PROGRAM Under the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking “, $173,000,000” and all that follows through “2011”, and inserting “, $200,000,000 for each of fiscal years 2011, 2012, and 2013.”

SEC. 2590. WEB SITE ON HEALTH CARE LABOR MARKET AND RELATED EDUCATIONAL AND TRAINING OPPORTUNITIES.

(a) In General.—The Secretary of Labor, in consultation with the National Center for Health Workforce Analysis, shall establish and maintain a Web site to serve as a comprehensive online resource and clearinghouse for information on—

(1) the type of jobs described in paragraph (1), including by—

(A) type of provider or program (such as public, private nonprofit, or private-for-profit);

(B) duration;

(C) cost (such as tuition, fees, books, laboratory expenses, and other mandatory costs);

(D) performance outcomes (such as graduation rates, job placement, average salary, job retention, and wage progression);

(E) out-of-pocket participation;

(F) average graduate loan debt;

(G) student loan default rates;

(H) average institutional grant aid provided;

(I) Federal and State accreditation information; and

(J) other information determined by the Secretary.

(2) Information on training and educational options for specific health care occupations to facilitate informed career and education choices.

(3) Financial aid information, including with respect to loan forgiveness, loan cancellation, scholarships, and grants or other assistance authorized by this Act or other Federal or State programs.

(c) PUBLIC ACCESSIBILITY.—The Web site maintained under this section shall—

(1) be publicly accessible;

(2) be user friendly and convey information in a manner that is easily understandable; and

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2591. ONLINE HEALTH WORKFORCE TRAINING PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

(1) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

(A) IN GENERAL.—The Secretary in consultation with the Secretary of Health and Human Services, shall establish an Online Health Workforce Training Program on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grants from Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs. An entity that is successful in receiving a grant under the program established under this paragraph—

(i) shall be an educational institution, community-based organization, non-profit organization, workforce investment board, or local or county government; and

(ii) shall provide online workforce training for individuals seeking to attain or advance in health care occupations.

(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, an entity shall—

(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

(iii) conduct training for occupations with national or local shortages.

(C) INFORMATION DISSEMINATION.—In awarding grants under this paragraph the Secretary shall—

(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

(iii) conduct training for occupations with national or local shortages.

(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

(i) the number of participants;

(ii) the services received by the participants;

(iii) program completion rates;

(iv) factors determined as significantly interfering with program participation or completion;

(v) the rate of job placement; and

(vi) other information as determined by the Secretary.

(E) Grantees under this paragraph shall conduct outreach activities to disseminate information about their programs and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be utilized to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected under the grantee on the indicators of performance.

(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this program $5,000,000 for fiscal years 2011 through 2020.

(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.

(A) DESCRIPTION OF GRANT.—The Secretary may award one or more grants to eligible postsecondary educational institutions to provide the services described in this paragraph.

(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

(i) provide technical assistance to entities that receive grants under paragraph (1);

(ii) collect and disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

(i) to provide technical assistance to entities that receive grants under paragraph (1); and

(ii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.

SEC. 2592. ACCESS TO CARE FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

(a) STANDARDS.—Not later than 9 months after the date of enactment of the Affordable Health Care for America Act, the Architectural and Transportation Barriers Compliance Board (Access Board) shall issue guidelines setting forth the minimum technical criteria for new medical diagnostic equipment to be purchased for use in (or in conjunction with) physician’s offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that the equipment is accessible to and usable by, individuals with disabilities, including provisions to ensure independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERAGE.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to new purchases of equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.
"(c) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

"(1) prescribe regulations in an accessible format as necessary to carry out the provisions of this Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

"(2) ensure that health care providers and health care plans covered by the Affordable Health Care for America Act meet the requirements of the Americans with Disabilities Act, including regulations ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

"(d) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board (Access Board) shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (c)."

SEC. 2593. DUPLICATIVE GRANT PROGRAMS.

(a) Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall conduct a study to determine if any new division C grant program is duplicative of one or more other grant programs of the Department of Health and Human Services that—

(1) are specifically authorized in the Public Health Service Act (42 U.S.C. 201 et seq.); or

(2) are receiving appropriations.

(b) DUPLICATIVE PROGRAMS.—If the Secretary determines under subsection (a) that a new grant program is duplicative of one or more other grant programs described in such subsection, the Secretary shall—

(1) attempt to integrate the new division C grant program with the duplicative programs; and

(2) if the Secretary determines that such integration is not appropriate or has not been successful, promulgate a rule eliminating the duplication, including, if appropriate, by terminating one or more programs.

(c) CONTINUED AVAILABILITY OF FUNDS.—Any funds appropriated to carry out a program that is terminated under subsection (b) are available for obligation for the one or more programs that—

(1) were determined under subsection (a) to be duplicative of such program; and

(2) remain in effect.

(d) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to the Congress and make publicly available a report that contains the results of the study required under subsection (a).

(e) CONGRESSIONAL REVIEW.—Any rule under subsection (b) terminating a program is deemed to be a major rule for purposes of chapter 8 of title 5, United States Code.

(f) DEFINITION.—In this section, the term ‘‘new division C grant program’’ means—

(1) a grant program first established by this division; and

(2) includes an existing program whose statutory authorization was in existence before the enactment of this division.

SEC. 2594. DIABETES SCREENING COLLABORATIVE AND OUTREACH PROGRAM.

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

(1) review utilization of diabetes screening benefits, consistent with recommendations of the Task Force on Clinical Preventive Services (established under section 311 of the Public Health Service Act as added by section 2301 of this Act), to identify and address any existing problems, with regard to uptake and utilization and related data collection; and

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

(b) CONSULTATION.—The Secretary shall carry out this section in consultation with—

(1) the heads of appropriate health agencies and programs in the Department of Health and Human Services, including the Office of Minority Health; and

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

(c) REPORT.—The Secretary shall submit an annual report to the Congress on the activities carried out under this section.

SEC. 2595. IMPROVEMENT OF VITAL STATISTICS COLLECTION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’), acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(1) promote the education and training of physicians on the importance of birth and death certification data and how to properly complete these documents in accordance with State law, including the collection of such data for diabetes and other chronic diseases as appropriate;

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

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

(b) DEATH CERTIFICATE ADDITIONAL LANGUAGES.—The Secretary may promote improvements to the collection of diabetes mortality data, including, as appropriate, the addition by States of any such language that the Secretary certifies will not cause of death regarding whether the deceased had diabetes.

SEC. 2596. NATIONAL HEALTH SERVICES CORPS.

(a) IN GENERAL.—The Indian Health Service (in this section referred to as the ‘‘Indian Health Service’’) may establish a demonstration program under which, in addition to the salary and benefits otherwise owed to a member of the National Health Services Corps, incentive payments are awarded to any such member who is assigned to a health professional shortage area with extreme need.

(b) REPORT.—The Secretary shall submit to the Congress an annual report on the demonstration program under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—Any funds appropriated to carry out this section are deemed to be appropriated such sums as may be necessary for such demonstration program under subsection (a).

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

SEC. 3001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the ‘‘Indian Health Care Improvement Act Amendments of 2009’’.

(b) TABLE OF CONTENTS.—The table of contents for this division is as follows:

TITLE I—AMENDMENTS TO INDIAN LAWS SEC. 3101. Expansion of payments under Medicare, Medicaid, and SCHIP for all covered services furnished by Indian Health Programs.

SEC. 3102. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid.

SEC. 3103. Solicitation of proposals for safe harbors under the Social Security Act for facilities of Indian Tribes.

SEC. 3104. Annual report on Indians served by Social Security Act health benefit programs.

SEC. 3105. Development of recommendations to improve interstate coordination of Medicaid and SCHIP coverage of Indian children and other children who are outside of their State of residency because of educational or other needs.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

SEC. 3201. Expansion of payments under Medicare, Medicaid, and SCHIP for all covered services furnished by Indian Health Programs.

SEC. 3202. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid.

SEC. 3203. Solicitation of proposals for safe harbors under the Social Security Act for facilities of Indian Health Programs and urban Indian organizations.

SEC. 3204. Annual report on Indians served by Social Security Act health benefit programs.

SEC. 3205. Development of recommendations to improve interstate coordination of Medicaid and SCHIP coverage of Indian children and other children who are outside of their State of residency because of educational or other needs.
Sec. 301. Consultation; construction and
renovation of facilities; reports.
Sec. 302. Sanitation facilities.
Sec. 303. Preference to Indians and Indian firms.
Sec. 304. Expenditure of non-Service funds for renovation.
Sec. 305. Funding for the construction, expansion, and modernization of rural ambulatory care facilities.
Sec. 306. Indian health care delivery demonstration project.
Sec. 307. Land transfers.
Sec. 308. Leases, contracts, and other agreements.
Sec. 309. Study of loans, loan guarantees, and loan repayment.
Sec. 310. Tribal leasing.
Sec. 311. Indian Health Service/tribal facilities joint venture program.
Sec. 312. Location of facilities.
Sec. 313. Maintenance and improvement of Indian Health Service facilities.
Sec. 314. Tribal management of federally owned quarters.
Sec. 315. Applicability of Buy American Act requirement.
Sec. 316. Other funding for facilities.
Sec. 317. Authorization of appropriations.
Sec. 318. Authorization of appropriations.
Sec. 319. Authorization of appropriations.
Sec. 320. Authorization of appropriations.
Sec. 321. Authorization of appropriations.
Sec. 322. Authorization of appropriations.
Sec. 323. Authorization of appropriations.
Sec. 324. Authorization of appropriations.
Sec. 325. Authorization of appropriations.
Sec. 326. Authorization of appropriations.
Sec. 327. Authorization of appropriations.
Sec. 328. Authorization of appropriations.
Sec. 329. Authorization of appropriations.
Sec. 331. Authorization of appropriations.
Sec. 332. Authorization of appropriations.
Sec. 333. Authorization of appropriations.
Sec. 334. Authorization of appropriations.
Sec. 335. Authorization of appropriations.
Sec. 336. Authorization of appropriations.
Sec. 337. Authorization of appropriations.
Sec. 338. Authorization of appropriations.
Sec. 339. Authorization of appropriations.
Sec. 341. Authorization of appropriations.
Sec. 342. Authorization of appropriations.
Sec. 343. Authorization of appropriations.
Sec. 344. Authorization of appropriations.
Sec. 345. Authorization of appropriations.
Sec. 346. Authorization of appropriations.
Sec. 347. Authorization of appropriations.
Sec. 348. Authorization of appropriations.
Sec. 349. Authorization of appropriations.
Sec. 350. Authorization of appropriations.
Sec. 351. Authorization of appropriations.
Sec. 352. Authorization of appropriations.
Sec. 353. Authorization of appropriations.
Sec. 354. Authorization of appropriations.
Sec. 355. Concurring with urban Indian organizations.
Sec. 356. Urban youth treatment center demonstration.
Sec. 357. Grants for diabetes prevention, treatment, and control.
Sec. 358. Community health representatives.
Sec. 359. Effective date.
Sec. 360. Eligibility for services.
Sec. 361. Establishment of the Indian Health Service as an agency of the Public Health Service.
Sec. 362. Automated management information system.
Sec. 363. Authorization of appropriations.
Sec. 364. Authorization of appropriations.
Sec. 365. Authorization of appropriations.
Sec. 366. Authorization of appropriations.
Sec. 367. Authorization of appropriations.
Sec. 368. Authorization of appropriations.
Sec. 369. Authorization of appropriations.
Sec. 370. Authorization of appropriations.
Sec. 371. Authorization of appropriations.
Sec. 372. Authorization of appropriations.
Sec. 373. Authorization of appropriations.
Sec. 374. Authorization of appropriations.
Sec. 375. Authorization of appropriations.
Sec. 376. Authorization of appropriations.
Sec. 377. Authorization of appropriations.
Sec. 378. Authorization of appropriations.
Sec. 379. Authorization of appropriations.
Sec. 380. Authorization of appropriations.
Sec. 381. Authorization of appropriations.
Sec. 382. Authorization of appropriations.
Sec. 383. Authorization of appropriations.
Sec. 384. Authorization of appropriations.
Sec. 385. Authorization of appropriations.
Sec. 386. Authorization of appropriations.
Sec. 387. Authorization of appropriations.
Sec. 388. Authorization of appropriations.
Sec. 389. Authorization of appropriations.
Sec. 390. Authorization of appropriations.
Sec. 391. Authorization of appropriations.
Sec. 392. Authorization of appropriations.
Sec. 393. Authorization of appropriations.
Sec. 394. Authorization of appropriations.
Sec. 395. Authorization of appropriations.
Sec. 396. Authorization of appropriations.
Sec. 397. Authorization of appropriations.
Sec. 398. Authorization of appropriations.
Sec. 399. Authorization of appropriations.
Sec. 400. Authorization of appropriations.
Sec. 401. Authorization of appropriations.
Sec. 402. Authorization of appropriations.
Sec. 403. Authorization of appropriations.
Sec. 404. Authorization of appropriations.
Sec. 405. Authorization of appropriations.
Sec. 407. Authorization of appropriations.
Sec. 408. Authorization of appropriations.
Sec. 409. Authorization of appropriations.
Sec. 410. Authorization of appropriations.
Sec. 411. Authorization of appropriations.
Sec. 412. Authorization of appropriations.
Sec. 413. Authorization of appropriations.
Sec. 414. Authorization of appropriations.
Sec. 415. Authorization of appropriations.
Sec. 416. Authorization of appropriations.
Sec. 417. Authorization of appropriations.
Sec. 418. Authorization of appropriations.
Sec. 419. Authorization of appropriations.
Sec. 420. Authorization of appropriations.
Sec. 421. Authorization of appropriations.
Sec. 422. Authorization of appropriations.
Sec. 423. Authorization of appropriations.
Sec. 424. Authorization of appropriations.
Sec. 425. Authorization of appropriations.
Sec. 426. Authorization of appropriations.
Sec. 427. Authorization of appropriations.
Sec. 428. Authorization of appropriations.
Sec. 429. Authorization of appropriations.
Sec. 430. Authorization of appropriations.
Sec. 431. Authorization of appropriations.
Sec. 432. Authorization of appropriations.
Sec. 433. Authorization of appropriations.
Sec. 434. Authorization of appropriations.
Sec. 435. Authorization of appropriations.
Sec. 436. Authorization of appropriations.
Sec. 437. Authorization of appropriations.
Sec. 438. Authorization of appropriations.
Sec. 439. Authorization of appropriations.
Sec. 440. Authorization of appropriations.
Sec. 441. Authorization of appropriations.
Sec. 442. Authorization of appropriations.
Sec. 443. Authorization of appropriations.
Sec. 444. Authorization of appropriations.
Sec. 446. Authorization of appropriations.
Sec. 447. Authorization of appropriations.
Sec. 448. Authorization of appropriations.
Sec. 449. Authorization of appropriations.
Sec. 450. Authorization of appropriations.
Congress declares that it is the policy of this Nation to carry out its trust responsibilities and legal obligations to Indians—

(1) to assure the highest possible health status of Urban Indians and to provide all resources necessary to effect that policy;

(2) to raise the health status of Indians and Urban Indians to at least the levels set forth in the goals contained within the Health People 2010 or successor objectives;

(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

(4) to increase the proportion of all degrees of health professionals and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

(6) to provide funding for programs and facilities that will permit Indian Tribes, Tribal Organizations, and Urban Indian Organizations in amounts that are not less than the amounts provided to programs and facilities operating directly by the Service.

SEC. 4. DEFINITIONS.

"For purposes of this Act:

(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

(2) The term 'Area Office' means an administrative or service office, including a reservation office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

(4)(A) The term 'behavioral health' means the blending of substance (including alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

(B) The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 805.

(6) The term 'community college' means—

(A) a tribal college or university, or

(B) a junior or community college.

(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

(8) The term 'consumer' means, unless otherwise designated, the Department of Health and Human Services.

(9) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

(A) controlling—

(i) the development of diabetes;

(ii) high blood pressure;

(iii) infectious agents;

(iv) injuries;

(v) occupational hazards and disabilities;

(vi) sexually transmittable diseases; and

(vii) toxic agents; and

(B) providing—

(i) fluoridation of water; and

(ii) immunizations.

(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, naturopathic medicine, and any other health profession.

(11) The term 'health promotion' means—

(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

(B) encouraging adequate and appropriate diet, exercise, and sleep;

(C) promoting education and work in conformity with physical and mental capacity;

(D) making available safe water and sanitary facilities;

(E) improving the physical, economic, cultural, psychological, and social environment;

(F) promoting culturally competent care; and

(G) providing adequate and appropriate programs, which may include—

(i) abuse prevention (mental and physical);

(ii) community health;

(iii) community safety;

(iv) consumer health education;

(v) diet and nutrition;

(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

(vii) environmental health;

(viii) exercise and physical fitness;

(ix) avoidance of fetal alcohol disorders;

(x) first aid and CPR education;

(xi) human growth and development;

(xii) injury prevention and personal safety;

(xiii) behavioral health;

(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xxx) safe and adequate water;

(xxxi) healthy work environments;

(xxxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

(xxxiii) stress control;

(xxxiv) substance abuse;

(xxxv) sanitary facilities;

(xxxvi) sudden infant death syndrome prevention;

(xxxvii) tobacco use cessation and reduction;

(xxxviii) violence prevention; and

(xxxix) activities to promote achievement of any of the objectives described in section 308.

(12) The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 805, except that, for the purpose of sections 102 and 103, the term also means any individual who—

(A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and the recognized now or in the future by the State in which they reside; or

(ii) is a descendant, in the first or second degree, of any such member;

(B) is an Eskimo or Aleut or other Alaska Native;

(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) is determined to be an Indian under regulations promulgated by the Secretary.

(13) The term 'Indian Health Program' means—

(A) any health program administered directly by the Service;

(B) any Tribal Health Program; or

(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 671) (commonly known as the 'Buy Indian Act').

(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(15) The term 'junior or community college' has the meaning given the term by section 23 of the Higher Education Act of 1965 (20 U.S.C. 1058(f)).

(16) The term 'reservation' means any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any portion thereof.

(17) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

(18) The term 'Service' means the Indian Health Service.

(19) The term 'Service Area' means the geographical area served by each Area Office.

(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

(21) The term 'telehealth' has the meaning given the term section 330(k)(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

(22) The term 'telemedicine' means telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients...
and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

"(23) The term "tribal college or university" has the meaning given the term in section 102 of the Higher Education Act (20 U.S.C. 102).

"(24) The term "Tribal Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, or activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"(25) The term "Tribal Organization" has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"(26) The term "Urban Center" means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

"(27) The term "Urban Indian" means any individual who is a member of a group or community in an Urban Center and who meets 1 or more of the following criteria:

(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

(B) The individual is an Eskimo, Aleut, or other Alaska Native.

(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

"(28) The term "urban Indian organization" means a nonprofit corporate body that is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) participate in the provision of health care services to any of the interested Indian groups and individuals; and (D) is capable of legally cooperating with other tribal and private entities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

"SEC. 101. INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT.

"The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and urban Indian organizations involved in the provision of health services.

"SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

"(a) In General.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities, Tribal Health Programs, or urban Indian organizations to assist such entities in meeting the costs of

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them to;

(A) enroll in courses of study in such health professions; or

(B) if they are not qualified to enroll in any study to undertake such postsecondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the retention of such individuals in, and in the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

(b) Grants.—

(1) Application.—No grant may be made under this section unless an application has been submitted to the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give a preference to applications submitted by Tribal Health Programs or urban Indian organizations.

(2) Amount of Grants; Payment.—The amount of a grant under this section shall be determined by the Secretary. Payments pursuant to this section may be made in advance of the necessity of the service, function, activity, or facility funded, in such case, in whole or in part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(3) COVERAGE OF EXPENSES.—A grant made under this section—

(A) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

(B) may cover costs of postsecondary education of any recipient leading to a baccalaureate degree in an approved program of study leading to a field of study in a health profession, such scholarship not to exceed $10,000 per year; and

(C) may cover costs of postsecondary education of any recipient leading to a baccalaureate degree in an approved program of study leading to a field of study in a health profession, such scholarship not to exceed $10,000 per year.

"SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

"(a) Scholarships Authorized.—The Secretary, acting through the Service, shall provide scholarships to Indians who—

(1) have successfully completed their high school education or high school equivalency; and

(2) have demonstrated the potential to successfully complete courses of study in the health professions.

(b) Purpose.—Scholarships provided pursuant to this section shall be for the following purposes:

(1) Compensatory preprofessional education of any recipient, such scholarship not to exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued under this Act) and at such intervals and on such conditions as provided for in regulations pursuant to this Act. To the extent not otherwise prohibited by law, such scholarship not to exceed 4 years.

(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved program of study leading to a field of study in a health profession, such scholarship not to exceed 4 years. An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.

"(c) Other Conditions.—Scholarships under this section—

(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

(2) shall not be denied solely on the basis of the applicant’s scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

(3) shall not be denied solely on the basis of such applicant’s eligibility for assistance or benefits under any other Federal program.

"SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) In General.—

(1) Application.—The Secretary, acting through the Service, shall make scholarship grants to Indians who are enrolled full or part time in accredited schools pursuing preprofessional education.

(2) The distribution of the scholarships among health professions on the basis of the relative needs of Indians for additional service in the health professions.

(3) Management of scholarships.—A scholarship shall be awarded under this section only to an Indian who will, by service in 1 or more of the following:

(A) a program specified under that paragraph that—

(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

(ii) serves the Indian Tribe in which the recipient is enrolled.

"(b) Distribution of scholarships.—In making assignments of Indian Health Scholarship recipients required to meet the active
duty service obligation described in paragraph (1), shall give priority to assigning individuals to service in those programs specified in paragraph (1) that have a need for health professionals in a particular geographic area to provide health care services as a result of individuals having breached contracts entered into under this section.

``(c) PART-TIME STUDENTS.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

``(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 1 year, as determined by the Secretary; and

``(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

``(A) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the Secretary); or

``(B) 2 years; and

``(3) the amount of the monthly stipend specified in section 338A(d)(1)(B) of the Public Health Service Act (42 U.S.C. 254l(d)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

``(d) BREACH OF CONTRACT.—

``(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 if that individual—

``(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

``(B) is dismissed from such educational institution for disciplinary reasons;

``(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

``(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of any obligation of the United States to the individual arising under such contract.

``(2) OTHER BREACHES.—If for any reason not specified in paragraph (1) an individual breaches a written contract by failing either to begin such individual’s service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (i) of section 115 in the manner provided for in such subsection.

``(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

``(4) WAIVER OR SUSPENSION OF OBLIGATIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(5) EXTREME HARDSHIP.—Notwithstanding any other provisions of this Act, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to receive funds made available under this section.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(5) EXTREME HARDSHIP.—Notwithstanding any other provisions of this Act, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to receive funds made available under this section.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.

``(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(7) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted for the year beginning on the initial date on which that payment is due, and if the bankruptcy court finds that the nondischarge of a scholarship would result in extreme hardship to the recipient; or

``(8) ENSURE QUALITY.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

``(A) it is not possible for the recipient to meet that obligation or make that payment; and

``(B) such waiver or suspension is consistent with carrying out the purposes of this Act.
determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year as determined by the Secretary, the Secretary acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

(1) provide a high standard of training for community health representatives to ensure that community health representatives provide quality health care, health promotion, and disease prevention services to Indian communities.

(2) The Community Health Representative Program of the Service, shall—

(a) provide a high standard of training for community health representatives to ensure that community health representatives provide quality health care, health promotion, and disease prevention services to Indian communities served by the Program;

(b) in order to provide such training, develop and maintain a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

(B) provides instruction and practical experience in health promotion, disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

(c) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

(d) maintain a system that provides close supervision of Community Health Representatives;

(e) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

(f) promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Indian Health Service Loan Repayment Program (hereinafter referred to as the ‘Loan Repayment Program’) in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and urban Indian organizations.

(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 338(b)(1)(B)(i)(IV) of the Public Health Service Act (42 U.S.C. 254l-1(b)(1)(B)(i)(IV))) and be scheduled to complete such course of study in the same year such individual applies to participate in such program or

(ii) in an approved graduate training program in a health profession or

(iii) have—

(A) service in a health profession; and

(B) license to practice a health profession;

(2) A(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;
“(B) meet the professional standards for civil service employment in the Service; or
“(C) be employed in an Indian Health Program or urban Indian organization without a service obligation.

“(3) submit to the Secretary an application for a contract described in subsection (e).

(C) ELIGIBILITY.—

“(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (b) in the case of the individual's breach of contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make an informed decision.

“(2) CLEAR LANGUAGE.—The application form, contract form, and all other information furnished by the Secretary with this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

“(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

(d) PRIORITIES.—

“(1) List.—Consistent with subsection (j), the Secretary shall annually:

“(A) identify the positions in each Indian Health Program or urban Indian organization for which there is a need or a vacancy; and

“(B) rank those positions in order of priority.

“(2) APPROVALS.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

“(A) give first priority to applications made by individual Indians; and

“(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

“(i) individuals recruited through the efforts of an Indian Health Program or urban Indian organization; and

“(ii) other individuals based on the priority determined by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (b) in the case of the individual's breach of contract.

“(e) RENTICIPANT CONTRACTS.—

“(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

“(2) CONTENTS OF CONTRACT.—The written contract described in this subsection between the Secretary and an individual shall contain—

“(A) an agreement under which—

“(I) pursuant to subparagraph (C), the Secretary agrees—

“(i) to accept loan payments on behalf of the individual

“(ii) in the case of an individual described in subsection (b)(1)—

“(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

“(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

“(III) to serve for a time period in this section referred to as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian Health Program or urban Indian organization to which the individual may be assigned by the Secretary;

“(B) a provision permitting the Secretary to extend for such longer additional periods, if the individual meets the criteria for the period of obligated service agreed to by the individual under subparagraph (A)(i)(III);

“(C) a 'reimbursement for any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section';

“(D) a statement of the damages to which the United States is entitled under subsection (k) for the individual's breach of the contract; and

“(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

“(2) AMOUNT.—For each year of obligated service under the Loan Repayment Program and other manpower programs of the Service for which the individual is entitled under subsection (e), the Secretary may pay—

“(A) tuition expenses;

“(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

“(C) reasonable living expenses as determined by the Secretary.

“(3) TIMING.—Any arrangement made by the Secretary to extend the period of obligated service under the Loan Repayment Program.

“(4) REIMBURSEMENTS FOR TAX LIABILITY.—

“(A) makes payments on behalf of the individual for taxes due on the amounts described in paragraphs (1) and (2); or

“(B) provides an incentive to serve in an Indian Health Program or urban Indian organization with the greatest shortages of health professionals, to participate in the Loan Repayment Program.

“(5) PAYMENT SCHEDULE.—The Secretary shall establish a schedule for the making of such payments.

“(6) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

“(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

“(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall apply to the Secretary in making loan repayments made for the taxable year involved; and

“(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall

“(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations are appropriate with respect to such purpose.

“(2) give priority to assigning individuals to serve in Tribal Health Programs and urban Indian organizations with the greatest shortages of health professionals, to participate in the Loan Repayment Program.

“(3) TIMELINESS.—Any arrangement made by the Secretary for extending the period of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

“(4) REMUNERATION FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual,

“(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the amount of loan repayments made for the taxable year involved; and

“(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

“(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of a loan for which a contract made under the Loan Repayment Program to establish a schedule for the making of such payments.

“(6) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

“(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

“(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

“(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall

“(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations are appropriate with respect to such purpose.

“(2) give priority to assigning individuals to serve in Tribal Health Programs and urban Indian organizations with the greatest shortages of health professionals, to participate in the Loan Repayment Program.

“(3) TIMELINESS.—Any arrangement made by the Secretary for extending the period of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

“(4) REMUNERATION FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual,

“(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the amount of loan repayments made for the taxable year involved; and

“(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

“(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of a loan for which a contract made under the Loan Repayment Program to establish a schedule for the making of such payments.

“(6) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

“(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

“(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall apply to the Secretary in making loan repayments made for the taxable year involved; and

“(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall

“(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations are appropriate with respect to such purpose.

“(2) give priority to assigning individuals to serve in Tribal Health Programs and urban Indian organizations with the greatest shortages of health professionals, to participate in the Loan Repayment Program.

“(3) TIMELINESS.—Any arrangement made by the Secretary for extending the period of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

“(4) REMUNERATION FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual,
“(A) is enrolled in the final year of a course of study and—

(i) fails to maintain an acceptable level of academic standing in the educational institution; or

(ii) voluntarily terminates such enrollment;

(iii) is dismissed from such educational institution before completion of such course of study; or

(B) is enrolled in a graduate training program and fails to complete such training program.

(2) OTHER BRIDGES; FORMULA FOR AMOUNT OWED.—If damages described in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual’s period of obligated service in accordance with subsection (e)(2), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula:

\[ A = 3Z(t-a) \]

where—

(A) ’A’ is the amount the United States is entitled to recover;

(B) ’Z’ is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury;

(C) ’t’ is the total number of months in the individual’s period of obligated service; and

(D) ’a’ is the number of months of such period served by such individual in accordance with this section.

(3) TIME PERIOD FOR REPAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

(4) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

(5) DELINQUENCY.—

(A) IN GENERAL.—If damages described in paragraph (4) are delinquent for 3 months, the Secretary, for the purpose of recovering such damages, may use collection agencies contracted with by the Administrator of General Services; or

(B) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

(6) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or urban Indian organizations for which recruitment or retention is difficult.

(7) The number of contracts described in subsection (e)(1) that are entered into with respect to each type of health profession.

(8) The amount of loan payments made under this section, in total and by health profession.

(9) The number of scholarships that are provided under sections 104 and 106 with respect to each health profession.

(10) The number of scholarships grants provided under sections 104 and 106, in total, and by health profession.

(11) The number of providers of health care that will be needed by Indian Health Programs and urban Indian organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.

(12) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or urban Indian organizations for which recruitment or retention is difficult.

(13) The amount of scholarship grants provided under sections 104 and 106, in total and by health profession.

(14) The number of loan repayment programs established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the ‘LRRF’). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110; and such amounts as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

(15) USE OF FUNDS.—

(A) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

(1) to which a scholarship recipient under section (a), where the educational costs are borne by the Service, is enrolled; and

(2) for the purpose of providing scholarships or recruit and retain health professionals who have worked in an Indian Health Program or urban Indian organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

(B) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation, in such event with respect to each individual entering the program after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for under section 110.

(C) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from Tribal
Health Programs and urban Indian organizations shall be given an equal opportunity to participate in the program under subsection (a).

SEC. 115. QUINTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

(a) Grants Authorized.—For the purpose of increasing the number of nurses, nurse midwifes, and advanced practice nurses who practice in rural and urban health care services to Indians, the Secretary, acting through the Service, shall provide grants under the following:

(1) to public or private schools of nursing;

(2) to Tribal colleges or universities;

(3) to programs that provide a preference to individuals who—

(A) are members of Indian Tribes in the Service Area;

(B) have completed at least 90 credits of coursework at an accredited college or university;

(C) have completed 2 years of study at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', and shall be known as the 'Quentin N. Burdick American Indians Into Nursing Program'.

Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

(4) to programs conducted by tribal colleges and universities.

(b) Conditions.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish agreements with the Bureau of Indian Affairs, in consultation with the Indian Tribes and urban Indian organizations, to provide grants under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

(c) Requirements.—Grants may only be made under this section to a community college which—

(A) is accredited;

(B) has entered into an agreement with an accredited college or university medical school, the terms of which—

(i) provide a program that enhances the transition and recruitment of students into accredited baccalaureate programs for the purpose of maintaining the program and recruiting students for the program;

(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

(D) has a qualified staff which has the appropriate certifications;

(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

(F) agrees to provide for Indian preference applicants for programs under this section.

(d) Technical Assistance.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish agreements with the Bureau of Indian Affairs, in consultation with the Indian Tribes and urban Indian organizations, to provide grants under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

(e) Priorities.—The requirements of subsection (b) are met, grant award priority
shall be provided to tribal colleges and universities in Service Areas where they exist.

**SEC. 119. RETENTION BONUS.**

(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in an Indian Health Program or urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position in which recruitment or retention of personnel is difficult; and

(2) the Secretary determines is needed by Indian Health Programs and urban Indian organizations:

(A) completed 2 years of employment with an Indian Health Program or urban Indian organization; or

(B) completed any service obligations incurred as a requirement of—

(i) any Federal scholarship program; or

(ii) any Federal education loan repayment program; and

(4) enters into an agreement with an Indian Health Program or urban Indian organization for continued payment for a period of not less than 1 year.

(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for an annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon term of service, except where the failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement plus interest as determined by the Secretary in accordance with section 109(c)(2)(B).

(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

(1) a position for which recruitment or retention is difficult; and

(2) necessary for providing health care services to Indians.

**SEC. 120. NURSING RESIDENCY PROGRAM.**

(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a national program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or urban Indian organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study with an Indian Health Program or urban Indian organization leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor's degree (in the case of a registered nurse), or advanced degrees or certifications in nursing and public health.

(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to 1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicians), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses), participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to require the individual to repay an amount of the educational costs determined in accordance with the formula specified subsection (d)(1) of Section 104 for individuals failing to graduate from their degree program, and subsection (l) of Section 110 for individuals failing to start or complete the obligated service.

**SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.**

(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall establish a national Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(3) provides for the establishment of teleconferencing capacity in health clinics located in areas served by community health aides or community health practitioners.

(b) SPECIFIC PROGRAM REQUIREMENTS.—

(1) The Secretary, acting through the Community Health Aide Program of the Service, shall—

(A) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(B) develop a system which will identify the needs of community health aides and community health practitioners.

(2) In order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section 3(2).

(3) REQUIREMENT.—In establishing a national Community Health Aide Program in accordance with paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program under paragraph (1) that—

(A) includes the training of Alaska Natives to serve in an Indian Health Program or urban Indian organization; and

(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

(4) NATIONALIZATION OF PROGRAM.—In establishing a national Community Health Aide Program under paragraph (1), the Secretary shall not include dental health aide therapist services.

(5) REQUIREMENT.—In establishing a national Community Health Aide Program under paragraph (1), the Secretary shall—

(A) coordinate the planning and development of the program with other Federal and local agencies, as the Secretary determines is—

(B) provide for the development of the program in accordance with section 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall establish a national Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(3) provides for the establishment of teleconferencing capacity in health clinics located in areas served by community health aides or community health practitioners.

(b) SPECIFIC PROGRAM REQUIREMENTS.—

(1) The Secretary, acting through the Community Health Aide Program of the Service, shall—

(A) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(B) develop a system which will identify the needs of community health aides and community health practitioners.

(2) In order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section 3(2);

(3) REQUIREMENT.—In establishing a national Community Health Aide Program in accordance with paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program under paragraph (1) that—

(A) includes the training of Alaska Natives to serve in an Indian Health Program or urban Indian organization; and

(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

(4) NATIONALIZATION OF PROGRAM.—In establishing a national Community Health Aide Program under paragraph (1), the Secretary shall not include dental health aide therapist services.

(5) REQUIREMENT.—In establishing a national Community Health Aide Program under paragraph (1), the Secretary shall—

(A) coordinate the planning and development of the program with other Federal and local agencies, as the Secretary determines is—

(B) provide for the development of the program in accordance with section 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall establish a national Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(3) provides for the establishment of teleconferencing capacity in health clinics located in areas served by community health aides or community health practitioners.

(b) SPECIFIC PROGRAM REQUIREMENTS.—

(1) The Secretary, acting through the Community Health Aide Program of the Service, shall—

(A) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(B) develop a system which will identify the needs of community health aides and community health practitioners.

(2) In order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section 3(2);
SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic health professional shortages in the region.

(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

(1) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

(2) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area served by the program.

SEC. 124. NATIONAL HEALTH SERVICE CORPS.

(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

(1) remove a member of the National Health Service Corps from an Indian Health Program or urban Indian organization; or

(2) withdraw funding used to support such members or any associated positions.

(b) DEMONSTRATION INDIAN HEALTH PROGRAMS.—At the request of an Indian Health Program, the services of a member of the National Health Service Corps assigned to an Indian Health Program may be limited to the persons who are eligible for services from such Program.

SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

(a) CONTRACTS AND GRANTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges, to develop educational curricula for substance abuse counseling.

(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 3 years. Such contract or grant may be renewed for an additional 2-year period upon request to the Secretary.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate counselors, provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

(e) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

(f) DEVELOPMENT.—For the purposes of this section, the term ‘educational curriculum’ means 1 or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, substance abuse counseling (including applications for renewals of which the Service will increase the health care staff providing behavioral health services to at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be submitted under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’).

(b) CRITERIA FOR REVIEW AND APPROVAL OF GRANTS.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

(c) DEVELOPMENT.—For the purposes of this section, the term ‘educational curriculum’ means 1 or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

SEC. 127. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Employees of a Tribal Health Program or an Urban Indian Organization shall be exempt from the following fees:

(1) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

(2) eliminating inequities in funding for both direct care and contract health service programs; and

(3) augmenting the ability of the Service to meet the following responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies:

(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care; and

(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

(C) Dental care.

(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

(E) Emergency medical services.

(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

(G) Services derived from the demonstration programs, including data collection and evaluation, demonstration projects, training, and capacity building.

(H) Home health care.

(1) Community health representatives.

(2) Maintenance and improvement.
‘(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under Act Amendments of 2009, and federal law (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), or any other provision of law.

‘(c) ALLOCATION; USE.—

‘(1) Tribal Health Programs.—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Service Unit, Indian Tribe, or Tribal Organization under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health and well-being of Indians by addressing any health resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

‘(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes and Tribal Organizations.

‘(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

‘(1) DEFINITION.—The term ‘health status and resource deficiency’ means the extent to which:

‘(A) the health status objectives set forth in section 3(2) are not being achieved; and

‘(B) the Indian Tribe or Tribal Organization can either not allocate to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

‘(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, State or local governments, and programs of State or local governments.

‘(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures for consideration of Indian Tribes or Tribal Organizations to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian Tribe or Tribal Organization.

‘(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on a basis that equitably applies to programs that are administered directly by the Service.

‘(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out—

‘(1) the methodology then in use by the Service for determining Tribal health status and resource deficiencies, as well as the most recent application of that methodology;

‘(2) the extent of the health status and resource deficiencies of each Indian Tribe served by the Service or a Tribal Health Program;

‘(3) the amount of funds necessary to eliminate the health status and resource deficiency of such Indian Tribe served by the Service or a Tribal Health Program; and

‘(4) an estimate of—

‘(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the purpose of determining the extent of the health status or resource deficiency of each Service Unit, Indian Tribe, or Tribal Organization;

‘(B) the number of Indians eligible for health services provided to such Service Unit, Indian Tribe, or Tribal Organization; and

‘(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe, or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

‘(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the fiscal year and used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph in subsequent fiscal years.

‘(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions intended to discourage the Service from undertaking additional efforts to achieve equity among Indian Tribes and Tribal Organizations.

‘(1) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the ‘Indian Health Care Improvement Fund’.

‘SEC. 202. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

‘(a) FINANCING.—Congress finds that health promotion and disease prevention activities—

‘(1) improve the health and well-being of Indians; and

‘(2) reduce the expenses for health care of Indians.

‘(b) PROVISION OF SERVICES.—The Secretary shall provide health promotion and disease prevention services to Indians to achieve the health status objectives set forth in section 3(2).

‘(c) EVALUATION.—The Secretary, after obtaining input from the affected Tribal Health Programs, shall submit to the President for inclusion in the report which is required to be submitted pursuant to subsection (a) of section 101 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

‘SEC. 203. DIABETES PREVENTION, TREATMENT, AND CONTROL.

‘(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

‘(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

‘(2) based on the determinations made pursuant to paragraph (1), the extent of, and the incidence of, diabetes among Service employees as the Secretary deems necessary to carry out the purposes of this section;
“(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

“(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

“(4) MINIMUM REQUIREMENT.—Any nursing facilities under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

“(d) USE OF FUNDS.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

“(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

“SEC. 205. HEALTH SERVICES RESEARCH.

“(a) IN GENERAL.—The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs.

“(b) USE OF RESOURCES AND ACTIVITIES.—The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.

“(c) AVAILABILITY.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

“(d) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

“(e) EVALUATION AND DISSEMINATION.—The Secretary shall periodically—

“(1) evaluate the impact of research conducted under this section; and

“(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

“SEC. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

“The Secretary, acting through the Service, shall provide for screening as follows:

“(1) Screening mammography (as defined in section 450b of title 20, United States Code) for Indian women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

“(2) Other cancer screening that receives an A or B rating as recommended by the United States Preventive Services Task Force (25 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

“(A) frequency;

“(B) the population to be served;

“(C) the procedure or technology to be used;

“(D) evidence of effectiveness; and

“(E) other matters that the Secretary determines under this section.

“SEC. 207. PATIENT TRAVEL COSTS.

“(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term ‘qualified escort’ means—

“(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient; and

“(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

“(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

“(b) PROVIDE OR FUND.—The Secretary, acting through the Service, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

“(1) emergency air transportation and non-emergency air transportation where ground transportation is inaccessible;

“(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

“(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

“(c) AVAILABILITY.—An A or B rating as recommended by the Task Force with respect to—

“(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

“(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

“(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

“(d) PROVIDE OR FUND.—The Secretary, acting through the Service, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

“(1) emergency air transportation and non-emergency air transportation where ground transportation is inaccessible;

“(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

“(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

“(e) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

“(f) EVALUATION AND DISSEMINATION.—The Secretary shall establish an epidemiology center in each Service Area to carry out the functions described in subsection (b). Any new center established after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

“(g) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

“(A) to carry out the functions described in subsection (b);

“(B) to provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff on health care and health service management issues; and

“(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

“(h) ACCESS TO INFORMATION.—

“(1) An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996, as such entities are defined in part 164.501 of title 45, Code of Federal Regulations.

“(2) The Secretary shall grant to such an epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other programs and health information in the possession of the Secretary.

“(3) The activities of such an epidemiology center shall be for the purposes of research activities preventing and controlling disease, injury, or disability for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such activities are described in part 164.512 of title 45, Code of Federal Regulations (or a successor regulation).

“(d) FUNDS NOT DIVISIBLE.—An epidemiology center established under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for such center shall not be divisible.

“SEC. 209. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

“(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, shall award grants to Indian Tribes and Tribal Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in those areas for the benefit of Indian children.

“(b) USE OF GRANT FUNDS.—A grant awarded under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for such center shall not be divisible.
"1) Developing health education materials both for regular school programs and after-school programs. "2) Training teachers in comprehensive scholastic community and public and private health promotion efforts. "3) Developing healthy, tobacco-free school environments. "4) Implementing a comprehensive school health education materials. "5) Coordinating school-based health programs with existing services and programs available in the community. "6) Developing school programs on nutrition education, personal health, oral health, and fitness. "7) Developing behavioral health wellness programs. "8) Developing chronic disease prevention programs. "9) Developing substance abuse prevention programs. "10) Developing injury prevention and safety education programs. "11) Developing activities for the prevention and control of communicable diseases. "12) Developing community and environmental health education programs that include individual and community health care practitioners. "13) Violence prevention. "14) Such other health issues as are appropriate. "(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes and Tribal Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources. "(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, after consultation with the Centers for Disease Control and Prevention, shall establish criteria for the review and approval of applications or proposals under this section. "(e) DEVELOPMENT OF PROGRAM FOR BIA-FUNDED SCHOOLS.— "(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs, shall, in cooperation with the Service, act through the Service, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs. "(2) REQUIREMENTS FOR PROGRAM.—Such programs shall include— "(A) services on nutrition education, personal health, oral health, and fitness; "(B) behavioral health wellness programs; "(C) chronic disease prevention programs; "(D) substance abuse prevention programs; "(E) injury prevention and safety education programs; and "(F) activities for the prevention and control of communicable diseases. "(3) DUTIES OF THE SECRETARY.—The Secretary shall— "(A) provide training to teachers in comprehensive school health education materials; "(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and "(C) encourage healthy, tobacco-free school environments. "SEC. 210. INDIAN YOUTH PROGRAM. "(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, shall establish and administer a program to provide grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for innovative mental and physical health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths. "(b) USES.— "(1) ALLOWABLE USES.—Funds made available under this section may be used to— "(A) develop prevention and treatment programs for Indian and urban Indian preadolescent and adolescent youths, which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and "(B) develop and provide community training and education. "(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(c). "(c) DUTIES OF THE SECRETARY.—The Secretary shall— "(1) disseminate to Indian Tribes, Tribal Organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents; "(2) encourage the implementation of such models; and "(3) at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance in the implementation of such models. "(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall establish criteria for the review and approval of applications or proposals under this section. "SEC. 211. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES. "(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall, in consultation with the Centers for Disease Control and Prevention, may make grants available to Indian Tribes, Tribal Organizations, and urban Indian organizations for the following: "(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. Pylori. "(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases. "(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals. "(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV). "(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary. "(c) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Indian Tribes, Tribal Organizations, and urban Indian organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies. "(d) TECHNICAL ASSISTANCE.—In carrying out this section, the Secretary— "(1) may, at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide assistance; and "(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward implementation and education Assistance Act (25 U.S.C. 450 et seq.) that are or will be provided in accordance with applicable standards. "(3) The term ‘hospice care’ means the services and items specified in subparagraph (A) through (F) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care. "(4) The term ‘long-term care’ has the meaning given the term ‘qualified long-term care services’ in section 1221 of the Internal Revenue Code of 1986. "(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, in consultation with Indian Tribes, Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 396d(c)(3)(A) of this Act. "SEC. 213. INDIAN WOMEN’S HEALTH CARE. "(a) AUTHORIZATION.—The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the present models of care for Indian women. "SEC. 214. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS. "(a) STUDIES AND MONITORING.—The Secretary shall establish and administer a program in conjunction with other appropriate Federal agencies and in consultation with concerned
Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and in Indian communities. Such studies shall include:

(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently existing among Indians and the causes of such health problems;

(2) an analysis of the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, ura-


minium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation near reservations and Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(4) any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of this Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health of safety of such Indians and;

(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively minimize or reduce such health and safety hazards of such development.

(b) HEALTH CARE PLANS. — Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include:

(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit the studies required under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009. The plan prepared pursuant to subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. The plan shall include recommendations for the implementation of the plan, as well as an evaluation of any activity undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established a Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy;

(B) The Secretary of the Environmental Protection Agency;

(C) The Director of the Bureau of Mines.

(D) The Secretary of Labor.

(E) The Secretary of Health and Human Services.

(F) The Director of the Indian Health Service.

(2) DUTIES.—The Task Force shall:

(A) identify existing and potential activities, practices, and conditions caus-


ing or affecting such health problems.

(B) evaluate the potential impact of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(C) assess the extent and nature of such health problems and the result of environmental hazards which may result in chronic or life threatening health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation near reservations and Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(D) evaluate the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(E) study the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(F) study the nature and extent of health problems caused by environmental hazards currently existing among Indians and the causes of such health problems;

(G) provide any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of this Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health of safety of such Indians and;

(H) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively minimize or reduce such health and safety hazards of such development.

(b) HEALTH CARE PLANS. — Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include:

(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit the studies required under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009. The plan prepared pursuant to subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. The plan shall include recommendations for the implementation of the plan, as well as an evaluation of any activity undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established a Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy;

(B) The Secretary of the Environmental Protection Agency;

(C) The Director of the Bureau of Mines.

(D) The Secretary of Labor.

(E) The Secretary of Health and Human Services.

(F) The Director of the Indian Health Service.

(2) DUTIES.—The Task Force shall:

(A) identify existing and potential activities, practices, and conditions caus-


 causing or affecting such health problems.

(B) evaluate the potential impact of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(C) assess the extent and nature of such health problems and the result of environmental hazards which may result in chronic or life threatening health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation near reservations and Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(D) evaluate the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(E) study the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(F) study the nature and extent of health problems caused by environmental hazards currently existing among Indians and the causes of such health problems;

(G) provide any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of this Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health of safety of such Indians and;

(H) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively minimize or reduce such health and safety hazards of such development.

(b) HEALTH CARE PLANS. — Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include:

(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit the studies required under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009. The plan prepared pursuant to subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. The plan shall include recommendations for the implementation of the plan, as well as an evaluation of any activity undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established a Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy;

(B) The Secretary of the Environmental Protection Agency;

(C) The Director of the Bureau of Mines.

(D) The Secretary of Labor.

(E) The Secretary of Health and Human Services.

(F) The Director of the Indian Health Service.

(2) DUTIES.—The Task Force shall:

(A) identify existing and potential activities, practices, and conditions caus-


 causing or affecting such health problems.

(B) evaluate the potential impact of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(C) assess the extent and nature of such health problems and the result of environmental hazards which may result in chronic or life threatening health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation near reservations and Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(D) evaluate the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(E) study the potential contributions of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(F) study the nature and extent of health problems caused by environmental hazards currently existing among Indians and the causes of such health problems;

(G) provide any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of this Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health of safety of such Indians and;

(H) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively minimize or reduce such health and safety hazards of such development.
**SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.**

"The Service shall provide funds for health care programs, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs, functions, services, activities, information technology, and facilities operated directly by the Service."

**SEC. 221. LICENSING.**

"Licensed health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) while performing such services."
“(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the priority system; and that once every 3 years, or more frequently as the Secretary determines to be appropriate.

(B) NEEDS OF FACILITIES UNDER ISDREA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this section, the Secretary, in evaluation of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

(D) PRIORITY OF CERTAIN PROJECTS PROJECTED TO RESULT FROM VETERANS SERVICE AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(E) FEDERAL FACILITIES.—The Secretary shall establish a comprehensive, national, prioritization and education assistance act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

(F) TRANSPORTATION SERVICES.—The Secretary shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

(G) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(H) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(I) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress under section 801, a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under paragraph (1), a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(C) REPORT; CONTENTS.—In a report submitted under paragraph (1), the Secretary shall include—

(aa) the methodology and criteria used by the Service in establishing priorities and re-evaluating the ranking of the facilities needs; and

(bb) such other information as the Secretary determines to be appropriate.

(D) REVIEWS OF METHODOLOGY USED FOR FACILITIES UNMET NEEDS.—The Secretary shall review the methodology used by the Secretary in establishing priorities under this Act, and report the results of such review to Congress under section 801.

(E) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(F) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(G) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(H) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(I) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress under section 801, a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under paragraph (1), a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(C) REPORT; CONTENTS.—In a report submitted under paragraph (1), the Secretary shall include—

(aa) the methodology and criteria used by the Service in establishing priorities and re-evaluating the ranking of the facilities needs; and

(bb) such other information as the Secretary determines to be appropriate.

(D) REVIEWS OF METHODOLOGY USED FOR FACILITIES UNMET NEEDS.—The Secretary shall review the methodology used by the Secretary in establishing priorities under this Act, and report the results of such review to Congress under section 801.

(E) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(F) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(G) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(H) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(I) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress under section 801, a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under paragraph (1), a report which sets forth the following:

(i) A description of the health care facility priority system.

(ii) A comprehensive list of all health care facilities needs.

(iii) The methodology adopted by the Secretary.

(iv) The project cost of each project.

(C) REPORT; CONTENTS.—In a report submitted under paragraph (1), the Secretary shall include—

(aa) the methodology and criteria used by the Service in establishing priorities and re-evaluating the ranking of the facilities needs; and

(bb) such other information as the Secretary determines to be appropriate.

(D) REVIEWS OF METHODOLOGY USED FOR FACILITIES UNMET NEEDS.—The Secretary shall review the methodology used by the Secretary in establishing priorities under this Act, and report the results of such review to Congress under section 801.

(E) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(F) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(G) PRIORITY TO COMMUNITY HEALTH CENTERS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.

(H) PRIORITY TO LONG-TERM CARE FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of facilities operated under a contract or compact in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully integrated into the health care facility priority system.
through the provision of sanitation facilities.

"(c) FUNDING.—Notwithstanding any other provision of law—

"(1) The Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 401 et seq.), to the Secretary of Health and Human Services;

"(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

"(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services for Indians under Federal programs for new projects to construct eligible sanitation facilities to serve Indian homes and facilities. The amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of the Indian Tribes and Indian communities shall be evaluated and reported to the President.

"(5) all Federal agencies are authorized to transfer to the Secretary funds identified, in whole or in part, that are administered directly by the Service (as defined in section 4 of the Act), to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities; and

"(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to fund up to 100 percent of the amount of an Indian Tribe’s loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes and facilities. The amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of the Indian Tribes and Indian communities shall be evaluated and reported to the President.

"(7) all Federal agencies are authorized to transfer to the Secretary funds identified, in whole or in part, that are administered directly by the Service (as defined in section 4 of the Act), to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities; and

"(8) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing financial assistance for sanitation facilities and services for Indians under this Act.

"(9) the Secretary of Health and Human Services shall, by regulation, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act; and

"(10) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Service from appropriate public authorities, nonprofit organizations or agencies, or Indian Tribes, as contributions by that authority, organization, agency, or tribe to agreements made under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), and such payments shall be credited to the same or subsequent appropriation account as funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(d) CERTAIN CAPABILITIES NOT PROHIBITED.—Nothing in this title shall be construed to prohibit such assistance to the Indian Tribes or construction of sanitation facilities by the Secretary.

"(e) FINANCIAL ASSISTANCE.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities in an amount equal to the amount otherwise set aside for the purpose of operating, managing, and maintaining the facilities provided under the plan described in subsection (c).

"(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the responsibility to establish, collect, and use fees, and otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity of the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance services.

"(g) ISDEEA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

"(1) any funds appropriated pursuant to this section; and

"(2) any funds appropriated for the purpose of providing sanitation facilities.

"(h) REPORT.—

"(1) REPORT CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Act of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4010)) shall submit to the President, in the annual report required to be transmitted to Congress under section 201, a report which sets forth—

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies and needs;

"(C) the criteria on which the deficiencies and needs are based;

"(D) the level of initial and final sanitation deficiency for each type of sanitation facility for each project of each Indian Tribe or Indian community;

"(E) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of the Indian Tribes and Indian communities level I sanitation deficiency as defined in paragraph (3)(A); and

"(F) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

"(2) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be uniformly applied to all Indian Tribes and Indian communities.

"(3) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels of all Indian Tribes and Indian communities shall be identified as follows:

"(A) a level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

"(i) complies with all applicable water supply, pollution control, and solid waste disposal laws; and

"(ii) deficiencies relate to routine replacement, repair, or maintenance.

"(B) a level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or completely lacks capacity to maintain the integrity of the health benefits of the sanitation facility, or permits solid waste facilities to exist but—

"(i) small or minor capital improvements need to be made to bring the facility back into compliance;

"(ii) capital improvements that are necessary to correct the deficiencies; or

"(iii) the lack of equipment or training by an individual, Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facility.

"(C) a level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets 1 or more of the following conditions—

"(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

"(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major improvements to correct the deficiencies; or

"(iii) there is no access to or no approved or permitted solid waste facility available.

"(D) a level IV deficiency exists if—

"(i) if a sanitation facility for an individual, Indian Tribe, or an Indian community exists but—

"(I) lacks—

"(aa) a safe water supply system; or

"(bb) a waste disposal system;

"(II) contains no piped water or sewer facilities; or

"(III) has become inoperable due to a major component failure; or

"(ii) if only a wastewater or central facility exists in the community.

"(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

"(i) DEFINITIONS.—For purposes of this section, the following terms apply:

"(A) COMMUNITY.—The term ‘Indian community’ means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

"(B) SANITATION FACILITIES.—The terms ‘sanitation facility’ and ‘sanitation facilities’ mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

"(g) FISHER INDIAN ACT.—

"(a) INDIAN TRIBES.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the ‘Buy Indian Act’), to give preference to Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federalized or organized Indian Tribes in the State of New York (hereinafter referred to as an ‘Indian firm’) in the creation and renewal of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unilaterally or in participation with other Federal or applicable State, local, or Tribal regulations, that the project or function to be contracted for will not be satisfactory or such
project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

'(1) ownership and control by Indians;
'(2) equipment;
'(3) bookkeeping and accounting procedures;
'(4) substantive knowledge of the project or function to be contracted for;
'(5) adequate personnel; or
'(6) other necessary components of contract performance.

'(b) Pay Rates.—For the purposes of implementing the provisions of this title, construction, renovation, or modernization of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part under this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the Davis-Bacon Act).

'(c) Labor Standards.—For the purposes of implementing the provisions of this title, construction, renovation, or modernization of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part under this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the Davis-Bacon Act).

'SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION.

'(a) In General.—Notwithstanding any other law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization of any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), including—

'(1) any plans or designs for such expansion, renovation, or modernization;
'(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended; and
'(3) the expansion, renovation, or modernization for which funds were lawfully appropriated under any Federal law.

'(b) Priority List.—

'(1) In General.—The Secretary shall maintain a separate priority list to address the needs of new facilities for increased operating expenses, personnel, or equipment for such facilities. The methodology for establishing priorities shall be developed through regulations. The list of priority facilities shall be revised annually in consultation with Indian Tribes and Tribal Organizations.

'(2) Report.—The Secretary shall submit to the Congress an annual report on the construction, expansion, or modernization of health care facilities pursuant to this section. The report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1), and the Secretary's findings under this subsection shall be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1), and the Secretary's findings under this subsection shall also be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

'(c) Requirements.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

'(1) the Indian Tribe or Tribal Organization—

'(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and
'(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel, or equipment; and
'(2) the expansion, renovation, or modernization—

'(A) is approved by the appropriate area director of the Service for Federal facilities; and
'(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

'(d) Adjacent Indian Tribes or Tribal Organizations.—In addition to the requirements under subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information pursuant to regulations, including additional staffing, equipment, and other costs associated with the construction, expansion, renovation, or modernization project that benefits the Service population identified above in subsection (b)(1)(C) and (ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization applying for a grant under this section for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

'GRANTS.—

'(1) In General.—The Secretary, acting through the Service, shall make grants to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of health care facilities for the purposes of providing health care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)) if the requirements of clauses (ii) and (iii) of paragraph (1)(C) are met, the Secretary, acting through the Service, shall consider whether the Indian Tribe or Tribal Organization in accordance with any provision of law, if the requirements of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1)(C) and regulations and has set forth reasonable assurance that, at all times after the completion of construction, expansion, or modernization of a facility carried out using a grant received under this section—

'(A) adequate financial support will be available for the provision of services at such facility; and
'(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment.

'(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

'(2) Priority.—In awarding grants under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

'(A) a need for increased ambulatory care services; and
'(B) sufficient capacity to deliver such services.

'(3) Peer Review Panels.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to subsection (a)(1).

'(d) Reversion of Facilities.—If any facility (or portion thereof) with respect to which funds have been paid under this section is abandoned, at any time after completion of the construction, expansion, renovation, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.

'(e) Funding Nonrecurring.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe’s tribal share for an award under the Indian Self-Determination and Education Assistance Act. The provisions of this section shall also apply to funds provided under paragraph (1)(C) of this section.

'SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through
are timely filed and meet the criteria specified in this section.

(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

(1) waive any leasing prohibition;

(2) permit carryover of funds appropriated for the provision of health care services;

(3) permit the use of other available funds;

(4) permit the use of funds or property donated from any source for project purposes;

(5) provide for the reversion of donated real or personal property to the donor; and

(6) permit the use of Service funds to make payments to other funds, including Federal funds.

(c) RACINE CROSSES.—The Secretary shall develop and promulgate regulations, not later than 1 year after the date of enactment of the Indian Patient Care Improvement Act Amendments of 2009, for the review and approval of applications submitted under this section.

(d) CRITERIA.—The Secretary may approve projects that meet the following criteria:

(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

(2) A significant number of Indians, including those with low health status, will be served by the project.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The project is economically viable.

(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

(e) PRE-RIGHTS REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications under criteria developed pursuant to subsection (d).

(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Areas to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

(1) Cass Lake, Minnesota.

(2) Mescalero, New Mexico.

(3) Owyhee, Nevada.

(4) Schurz, Nevada.

(5) Yuma, California.

(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

(h) SERVICE TO INELIGIBLE PERSONS.—Subject to the authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 306 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

(i) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), use the same criteria for evaluating facilities under this section.

(j) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, operation, and expansion needs of Service and non-Servicel facilities which are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstrations under this section.

SEC. 307. LAND TRANSFER.

Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, or (2) a leasehold, (3) a beneficial interest in, (4) hostels; and (5) the maximum percentage of funds available under section 806(c) may be included in any projection of patient population.

The Secretary may make loans or loan guarantees covered through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs.

(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

SEC. 310. TRIBAL LEASING.

A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining the approval of the Secretary under section 310. The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease or in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project;

(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project; or

(3) in its application for a joint venture agreement, agrees—

(A) to construct a facility for the joint venture which complies with the size and space criteria established by the Service; or

(B) that if the facility it proposes for the joint venture is already in existence or under construction, that only the portion of such facility which complies with the size and space criteria of the Service will be eligible for the joint venture agreement.

(4) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate.

(5) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs.

(6) whether acceptance by the Secretary of the recommendation of the Committee on Indian Affairs of the House of Representatives a report that describes—

(1) the manner of the regulation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease or in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project;

(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project; or
the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facilities; and

(2) The Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, unless determined, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of such facilities.

(c) **CONTINUED OPERATION.**—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10-year no-cost lease period.

(d) **BREACH OF AGREEMENT.**—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe’s or Tribal Organization’s behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment less depreciation, and any funds expended for operations and maintenance under the agreement. A proceeding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

(e) Recovery for Nonuse.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

(f) **DEFINITION.**—For the purposes of this section, the term ‘health facility’ or ‘health facilities’ includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

**SECTION 312. LOCATION OF FACILITIES.**

(a) United States.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemploy ment in Alaska Native, Indian, or federalized economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any land allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization shall be entitled to Federal property, including land owned by 1 or more Indian Tribes.

(b) **DEFINITION.**—For purposes of this section, the term ‘Indian lands’ means

(1) all lands within the exterior boundaries of any reservation; and

(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States again the Indian Act.

**SECTION 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.**

(a) **Recovery.**—The Secretary shall submit to the Congress in the annual report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The Secretary shall notify the Congress of the need for renovation and expansion of existing facilities to support the growth of health care programs.

(b) **MAINTENANCE OF NEWLY CONSTRUCTED SPACE.**—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the health care facility priority system under section 301(c).

(c) **REPLACEMENT FACILITIES.**—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The Secretary shall consult with Indian Tribes and Tribal Organizations in determining the maximum renovation cost threshold.

**SECTION 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.**

(a) **RENTAL RATES.**

(1) **RENTAL AGREEMENT.**—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish revised rental rates for the occupancy of such quarters by providing notice to the Secretary of its election to exercise such authority.

(2) **OBJECTIVES.**—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of capital equipment.

(c) **EQUITABLE FUNDING.**—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

(d) **NOTICE OF RATE CHANGE.**—A Tribal Health Program which exercises the authority provided for in this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

(e) **DIRECT COLLECTION OF RENT.**—(1) In addition to any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees in any Federal facility that is proportioned. The Secretary shall notify the federal employment the authority to collect rents directly from such Federal employees.

(2) Upon receipt of a notice described in subparagraph (A), the Department of the Treasury shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

(C) Such rent payments shall be retained by the Secretary under this section, and shall not be made payable to or otherwise be deposited with the United States.

(D) Such rent payments shall be deposited in a separate account used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and shall be at the Tribal Health Program shall determine.

(2) **RETIROCESS OF AUTHORITY.**—If a Tribal Health Program which has made an election under this subsection is no longer entitled to exercise its reversion of its authority to directly collect rents from Federal employees occupying federally owned quarters, such reversion shall become effective on the earlier of—

(1) The first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

(2) Such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

**SECTION 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.**

(a) **APPLICABILITY.**—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

(b) **EFFECT OF VIOLATION.**—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a ‘Made in America’ inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not produced in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the determination and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

**SECTION 316. OTHER FUNDING FOR FACILITIES.**

(a) **DEFINITIONS.**—For purposes of this section, the term ‘Buy American Act’ means title III of the Act entitled ‘An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes’, approved March 3, 1933 (41 U.S.C. 10a et seq.).

(b) **INTERAGENCY AGREEMENTS.**—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

(c) **REJECTION.**—The Secretary is authorized to enter into interagency agreements with other Federal agencies to accept funds from such Federal or State agencies or other sources to provide for the
planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which such funds are appropriated or for which the funds were otherwise provided.

(2) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

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

TITLE II—ACCESS TO HEALTH SERVICES

SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

(a) DISHAORD OF MEDICARE, MEDICAID, AND SCHIP DETERMINATION AND PAYMENTS.—Any payments received by an Indian Health Program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided by such Program during the period of such election.

(b) DIRECT BILLING.—

(1) IN GENERAL.—Subject to complying with the provisions of paragraph (2), the Tribal Health Program may elect to directly bill for, and receive payment for, health care services furnished by such Program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act.

(2) DIRECT REIMBURSEMENT.—

(A) Use of Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act administered directly by that program for items and services furnished without regard to subsection (c)(1), but all amounts so reimbursed shall be used by the Tribal Health Program for the same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service under paragraph (2) of such subsection with respect to the Service.

(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program. The Secretary shall construe as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

(c) USE OF FUNDS.—

(1) SPECIAL FUND.—

(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that 100 percent of the amount received by the Service Unit makes collections, is collected by reason of a provision of either such title.

(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to the extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the program or service operated by the Service Unit through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian Tribes being served by the Service Unit, be used for increasing the facility’s capacity to provide, or improving the quality or accessibility of, services.

(2) PROHIBITION.—Nothing in this section shall not apply to a Tribal Health Program upon the election of such Program under subsection (d) to receive payments directly. The provisions of such subparagraph shall be made applicable to the special fund described in such paragraph with respect to reimbursement made for services provided by such Program during the period of such election.

(3) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a Tribal Health Program or in the direct billing program by the Secretary determined that the Program has failed to comply with the requirements of subparagraph (A). The Secretary shall provide a Tribal Health Program with notice of a determination that the Program has failed to comply with such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the Program’s participation in the direct billing program established under this subsection.

(4) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—Sections related to subsections (c) and (d), see sections 1880, 1911, and 207(c)(1)(D) of the Social Security Act.

SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS FOR FACILITY OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to and contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs to provide outreach, enrollment, and coverage of Indians under the Social Security Act.

(1) TO ENROLL FOR BENEFITS.—The Secretary shall make grants to and contracts with Indian Tribes and Tribal Organizations in establishing and administering programs to enroll eligible Indians and the benefit program, to assist individual Indian organizations in establishing and administering programs to enroll eligible Indians and the benefit program, to assist individual Indian organizations in establishing and administering programs to enroll eligible Indians and the benefit program.

(b) SERVICES.—The Secretary shall make grants to and contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs to assist individual Indian organizations in establishing and administering programs to assist individual Indian organizations.

(c) USE OF FUNDS.—Any Indian Tribe or Tribal Organization making the election described in paragraph (2) of subsection (c) of such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service under paragraph (2) of such subsection with respect to the Service.

(d) IN GENERAL.—The Secretary, acting through the Service, shall pay to a Tribal Health Program operating under title XVIII, XIX, or XXI of the Social Security Act, the costs of enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program.

(2) TO PROVIDE TRANSPORTATION.—The Secretary shall pay to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to payments made in lieu of cost sharing for such programs for which the charging of premiums and cost sharing is suppressed or cost sharing for benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes or Tribal Organizations) and family income levels developed or implemented by such Tribes, Tribes, or Tribal Organizations.

(b) CONDITIONS.—The Secretary, acting through the Service, shall make grants to and contracts with Indian Tribes and Tribal Organizations pursuant to this section. Such conditions shall include requirements that an Indian Tribe or Tribal Organization successfully undertake—

(1) to determine the population of Indians eligible for the benefits described in section (a);

(2) to educate Indians with respect to the benefits available under the respective programs;

(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and funding to urban Indian organizations with respect to populations served by such organizations in the same manner they are applied to grants and funding to Tribal Health Programs and Tribal Organizations with respect to programs on or near reservations.
services were provided is covered under—

1139 of the Social Security Act.

Act, see subsections (a) and (b) of section

360 health insurance programs established under

358 assistance under the Medicaid and children's

356 Tribal Organizations, and urban Indian orga-

354 nations relating to agreements between the

352 States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations relating to en-

348 rollment and retention of Indians in pro-

346 grams established under titles XVIII, XIX, and XXI of the Social Security Act.

344 (e) AGREEMENTS TO IMPROVE ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT

342 HEALTH BENEFITS PROGRAMS.—For provi-

340 sions relating to agreements between the Secretary and the Service, Indian Tribes, Tribal Organizations, and urban Indian organiza-

338 tions for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare pro-

336 gram, see sections 1151 through 1159 of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

334 (f) DEFINITIONS.—In this section:

332 (1) PREMIUM.—The term ‘premium’ in-

330 cludes any enrollment fee or similar charge.

328 (2) COST SHARING.—The term ‘cost shar-

326 ing’ includes deductibles, co-payment, coinsurance, or similar charge.

324 (3) BENEFITS.—The term ‘benefits’ means,

322 with respect to—

319 (A) title XVII of the Social Security Act, benefits under such title;

317 (B) title XIX of such Act, medical assistance under such title; and

315 (C) title XXI of such Act, assistance under such title.

313 (g) COSTS AND ATTORNEYS’ FEES.—In any

311 action to recover from the tortfeasor for any health services provided by or through a Service

309 organization, respectively, and may be used as pro-

307 vides, either before or during the pendency of such action.

305 (3) RECOVERY FROM TORTFEASORS.—

303 (A) IN GENERAL.—In any case in which an Indian Tribe or Tribal Organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-

301 Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of en-

301 actment of the Indian Health Care Improvement Act Amendments of 2009 under cir-

301 sumstances that established grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian Tribe or Tribal Organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same conditions as United States recoveries under that Act.

301 (B) TREATMENT.—The right of an Indian Tribe or Tribal Organization to recover the costs of health services provided by the Service, by an Indian Tribe, or Tribal Organization may be exercised under section 1139 of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

301 (c) LIMITATION.—Absent specific written

301 authorization by the governing body of an Indian Tribe for the period of such authoriza-

301 tion, paragraph (1) shall not be of force or effect for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service, the United States shall not have the right of recovery under this sec-

301 tion if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, or Tribal Organization to a person who is injured or disabled. Where such authoriza-

301 tion is provided, the Service may receive and expend such amounts for the provision of ad-

301 ditional health services consistent with such authorization.

301 (d) COSTS AND ATTORNEYS’ FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys’ fees and costs of litigation.

301 (e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organiza-

301 tions with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organiza-

301 tions with respect to populations served by such Organizations.

301 (f) LIMITATION.—Absent specific written

301 authorization by the governing body of an Indian Tribe for the period of such authoriza-

301 tion, paragraph (1) shall not be of force or effect for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service, the United States shall not have the right of recovery under this sec-

301 tion if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, or Tribal Organization to a person who is injured or disabled. Where such authoriza-

301 tion is provided, the Service may receive and expend such amounts for the provision of ad-

301 ditional health services consistent with such authorization.

301 (g) COSTS AND ATTORNEYS’ FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys’ fees and costs of litigation.

301 (h) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organiza-

301 tions with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organiza-

301 tions with respect to populations served by such Organizations.

301 (i) STATUTE OF LIMITATIONS.—The provi-

301 sions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, whether brought in the courts of the United States or in the courts of any State. Where-

301 nate to the United States are deemed to in-

301 clude Indian Tribes, Tribal Organizations, and urban Indian organizations.

301 (j) SAVINGS.—Nothing in this section shall be construed to limit any right of re-

301 coverage available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws.

301 (k) RETENTION OF AMOUNTS FOR USE BY PROVIDERS.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 806 (relating to health services for ineligible persons), all re-

301 imbursements received or recovered, includ-

301 ing under section 806, by reason of the provi-

301 sion of health services by the Service, by an Indian Tribe or Tribal Organization, or by an urban Indian organization accredited to the Service, such Indian Tribe or Tribal Organization, or such urban Indian organiza-

301 tion, respectively, and may be used as pro-

301 vides, either before or during the pendency of such action.

301 (l) No ORPVR or ORPVR, (The Service

301 may not offset or limit any amount obli-

301 gated to any Service Unit or entity receiving the Service Unit of the retention of revalues for the benefit of the Service, or the receipt of reimbursements under subsection (a).

301 (m) PURCHASING COVERAGE.—

301 (1) IN GENERAL.—Insofar as amounts are

301 made available under law (including a provi-

301 sion of the Social Security Act, the Indian Self-Determination and Education Assist-

301 ance Act (25 U.S.C. 450 et seq.), or other law, other than under subsection 402) to In-

301 dian Tribes, Tribal Organizations, and urban In-

301 dian organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and urban Indian organizations may use such amounts to purchase benefits or services as creditable coverage under section 2701(c)(1) of the Public Health Service Act for such beneficiaries, including, subject to paragraph (2) of subsection (a) provided—

301 (A) a tribally owned and operated health care plan;
“(B) a State or locally authorized or li-"
to the State of Arizona, New Mexico, or Utah:

(2) providing assistance to the Navajo Na-

tion in the development and implementation

of such entity for the administration, eligi-

bility, payment, and delivery of medical as-

sistance under title XIX of the Social Secu-

rity Act;

(3) providing an appropriate level of match-

ing funds for Federal medical assist-

ance with respect to amounts such entity ex-

pends for medical assistance for services and

related entity for the administration of

related services; and

(4) authorizing the Secretary, at the op-

tion of the Navajo Nation, to treat the Nav-

ajo Nation as a State for the purposes of

title XIX of the Social Security Act (relating

to the State children’s health insurance pro-

gram) under terms equivalent to those de-

scribed in paragraphs (2) through (4).

(c) Report.—Not later than 3 years after

the date of enactment of the Indian Health

Care Improvement Act Amendments of 2009,

the Secretary shall submit to the Committee

on Indian Affairs and Committee on Finance

of the Senate and the Committee on Natural

Resources and Committee on Energy and

Commerce of the House of Representatives a

report that includes:

(1) the results of the study under this sec-

tion;

(2) a summary of any consultation that

occurred with the Secretary and the Nav-

ajo Nation, other Indian Tribes, the States of

Arizona, New Mexico, and Utah, counties

which include Navajo Lands, and other inter-

ested parties in conducting this study;

(3) projected costs or savings associated

with establishment of such entity, and any

estimated impact on services provided as de-

scribed in paragraphs (2) through (4); and

(4) legislative actions that would be re-

quired to authorize the establishment of

such entity as determined by the Secretary

to be feasible.

SEC. 414. EXCEPTION FOR EXCEPTED BENEFITS.

(a) Access or Services Provided.—The Sec-

retary, acting through the Service, shall facili-
	sate access to, or provide, behavioral

health services for Urban Indians through

grants made to urban Indian organizations

administering contracts entered into or re-

ceiving grants under subsection (a).

(b) Assessment Required.—Except as pro-

vided by paragraph (3)(A), a grant may not be

made under this subsection to an urban

Indian organization until that organization has

prepared, and the Service has approved,

an assessment of the following:

(1) the behavioral health needs of the

urban Indian population concerned;

(2) the extent of existing or likely future

participation in the activities set forth in

subsection (a) by appropriate health and

health-related Federal, State, local, and

other agencies.

(c) Access to Health Promotion and

Disease Prevention Programs.—The Sec-

retary, acting through the Service, shall pro-

vide direct outreach, educational, and refer-

al services to Urban Indians regarding the

availability of direct behavioral health

services and programs, including behav-

ioral health issues and services, and ef-

fect coordination with existing behavioral

health providers in order to improve services

to Urban Indians;

(D) To develop innovative behavioral

health service delivery models which incor-

porate Indian cultural support systems

and resources.

(1) Prevention of Child Abuse.—

(a) Access or Services Provided.—The

Secretary, acting through the Service, shall

facilitate access to or provide services for

Urban Indians through grants to urban In-

dian organizations administering contracts

entered into or receiving grants under sub-

section (a) to prevent and treat child abuse

(including sexual abuse) among Urban Indi-

ans.

(b) Evaluation Required.—Except as pro-

vided by paragraph (3)(A), a grant may not

be made under this subsection to an urban

Indian organization until that organization

has prepared, and the Service has approved,

an assessment that documents the prev-

alence of child abuse in the urban Indian

population concerned and specifies the services

and programs (which may not duplicate ex-

isting services and programs) for which the

grant is requested.

(c) Exceptions of Grants.—Grants may be

made under this subsection for the following:

(1) To prepare assessments required

under paragraph (2).

(2) To provide direct outpatient treat-

ment services (including individual treat-

ment, family treatment, group therapy, and

support groups) to Urban Indians who are

child victims of abuse (other than sexual abuse)
or adult survivors of child sexual abuse, to the

families of such child victims,
and to urban Indian perpetrators of child abuse (including sexual abuse).

“(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

“(A) the support for the urban Indian organization demonstrated by the child protection and domestic abuse programs in the area, including programs funded by Federal, State, local, or other entities.

“(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

“(C) any assessment required under paragraph (2).

“(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an urban Indian organization that provides or arranges for the provision of health care services (through satellites, facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

“SEC. 504. USE OF FEDERAL GOVERNMENT FA- SURD SOURCES OF SUPPLY.

“(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

“(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsection (b) or (c) from an urban Indian organization and from an Indian Tribe or Tribal Organization if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

“(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the contract or grant to prevent future occurrences of noncompliance or unsatisfactory performance.

“(c) GRANT AND CONTRACT REQUIRE- MENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

“(1) the urban Indian organization successfully undertakes to—

“(A) document the health care status and unmet health care needs of urban Indians in the Urban Center involved; and

“(B) with respect to urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

“(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

“(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

“SEC. 506. EVALUATIONS; RENEWALS.

“(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to ensure compliance with grant requirements and compliance with and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

“(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian Organization that has entered into a contract or grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, the Secretary shall—

“(1) act in writing, conduct an annual onsite evaluation of the organization; or

“(2) accept in lieu of such onsite evaluation evidence of the provision of full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in Medicare and Medicaid programs under title XVIII of the Social Security Act.

“(c) NONCOMPLIANCE; UNSATISFACTORY PER- FORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the urban Indian organization the matters described in subsections (a) and (b) of section 503. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and pre-
“(1) In general.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, each urban Indian organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

(A) a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

(B) Information on activities conducted by the organization pursuant to the contract or grant.

(C) An accounting of the amounts and purpose for which Federal funds were expended.

(D) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with urban Indian organizations.

(2) Health status and services.—

(A) In general.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall submit to Congress a report evaluating—

(i) the health status of urban Indians;

(ii) the services provided to Indians pursuant to this title; and

(iii) areas of unmet needs in the delivery of health services to urban Indians.

(B) Consultation and contracts.—In preparing the report under paragraph (1), the Secretary—

(i) shall consult with urban Indian organizations; and

(ii) may enter into a contract with a national organization representing urban Indian organizations to conduct any aspect of the report.

(3) Audit.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

(4) Costs of audits.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

(A) a certified public accountant; or

(B) a certified public accounting firm qualified to conduct Federal compliance audits.

SEC. 509. LIMITATION ON CONTRACT AUTHORITY.

The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

SEC. 510. FACILITIES.

(a) Grants.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for facilities to urban Indians.

(b) Loan Fund Study.—The Secretary, acting through the Service, may carry out a study to determine the feasibility of establishing a loan fund to provide to urban Indian organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with section 309, including by submitting a report in accordance with subsection (c) of that section.

SEC. 511. DIVISION OF URBAN INDIAN HEALTH.

There is established within the Service a Division of Urban Indian Health, which shall be responsible for—

(1) carrying out the provisions of this title;

(2) providing central oversight of the programs and services authorized under this title; and

(3) providing technical assistance to urban Indian organizations.

SEC. 512. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

(a) Grants Authorized.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Urban Centers to those urban Indian organizations with which the Secretary has entered into a contract under this title or under section 503.

(b) Goals.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant.

(c) Eligibility.—Urban Indian organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

(d) Report.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

SEC. 513. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

(1) Notwithstanding any other provision of law, the Tulia Clinic and Oklahoma City Clinic demonstration projects shall—

(A) cease to be treated as Service Units and Operating Units in the allocation of resources and coordination of care; and

(B) remain treated as nearly self-sufficient under the grant made under subsection (a).

SEC. 514. URBAN NIAAA TRANSFERRED PROGRAMS.

(a) Grants and Contracts.—The Secretary, through the Division of Urban Indian Health, shall make grants or enter into contracts with urban Indian organizations, to take effect not later than September 30, 2010, for the administration of urban Indian alcohol programs that were originally established by the National Institute on Alcoholism and Alcohol Abuse (hereinafter in this section referred to as ‘NIAAA’) and transferred to the Service.

(b) Use of Funds.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and shall be in addition to any facilities constructed under section 707(b).

(c) Eligibility.—Urban Indian organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

(d) Report.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

SEC. 515. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

(a) In general.—The Secretary shall ensure that the Service confers or conferences, to the greatest extent practicable, with Urban Indian Organizations.

(b) Definition of conference.—In this section, the terms ‘confer’ and ‘conference’ mean an open and free exchange of information and opinions that—

(1) leads to mutual understanding and comprehension; and

(2) emphasizes trust, respect, and shared responsibility.

SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

(a) Construction and Operation.—

(i) In general.—The Secretary, acting through the Service, shall make grants to urban Indian organizations for the construction and operation of 1 residential treatment center in each Service Area that meets the eligibility requirements set forth in paragraphs (b) through (d) of this section.

(b) Eligibility Requirements.—To be eligible to obtain a facility under subsection (a)(1), a Service Area shall meet the following eligibility requirements:

(1) There is an Urban Indian Organization in the Service Area.

(2) There reside in the Service Area Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting.

(3) There is a significant shortage of culturally competent residential treatment services for Urban Indian youth in the Service Area.

(c) Establishment of Criteria.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the size and location of the urban Indian population to be served;

(2) the need for prevention, treatment, and control of the complications resulting from, diabetes among urban Indians.

(d) Goals.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to the criteria to which the grant is subject.

SEC. 517. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

(a) Grants Authorized.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention, treatment, and control of the complications resulting from diabetes among urban Indians.

(b) Goals.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to the criteria to which the grant is subject.

(c) Establishment of Criteria.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the size and location of the urban Indian population to be served;

(2) the need for prevention, treatment, and control of the complications resulting from diabetes among urban Indians.

(d) Performance Standards.—For the grants made under this section, the Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the health status of urban Indian population to be served;

(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among urban Indians.

(3) the capability requirements set forth in subsection (c);

(4) the capability of the organization to adequately perform the activities required under the grant.
“(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 203(e)(1)(B) in the Area Office of the Service in which the organization is located.

“(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

“SEC. 518. COMMUNITY HEALTH REPRESENTA-

“The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to urban Indians.

“SEC. 519. EFFECTIVE DATE.

“The amendments made by the Indian Health Care Improvement Act Amendments of 2009 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

“SEC. 520. ELIGIBILITY FOR SERVICES.

“Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

“SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

“(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

“(b) URBAN INDIAN ORGANIZATIONS.—The Secretary, acting through the Service, is authorized to establish programs, including programs covering grants to, urban Indian organizations that are identical to any programs established pursuant to section 126 (behavioral health training), section 209 (school health education), section 211 (prevention of communicable diseases), section 701 (behavioral health prevention and treatment services), and section 707(g) (multidrug abuse program).

“SEC. 522. HEALTH INFORMATION TECHNOLOGY.

“The Secretary, acting through the Service, may make grants to urban Indian organizations for the development, adoption, and implementation of health information technology (as defined in section 30005) of the American Recovery and Reinvestment Act of 2009 implementing and related infrastructure.

“TITLE VI—ORGANIZATIONAL

“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—In order to more effectively carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaty, there is established within the Public Health Service of the Department the Indian Health Service.

“(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2010, the term of service of the Assistant Secretary shall be 4 years.

“An Assistant Secretary may serve more than 1 term.

“(3) INCUMBENT.—The individual serving in the position of Director of the Service on the date of enactment of this Act shall be deemed to have been appointed to the position of Director of the Service created under the Indian Health Care Improvement Act Amendments of 2009 to serve as Assistant Secretary.

“(d) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

“(A) facilitate advocacy for the development of appropriate Indian health policy; and

“(B) promote consultation on matters relating to Indian health.

“(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any other act of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

“SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—The Secretary shall establish an automated management information system for the Service.

“(b) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

“(A) a financial management system; and

“(B) a patient care information system for each area served by the Service.

“(2) PROVISION OF SERVICES.—Notwithstanding any other provision of law, the Secretaries may enter into contracts, agreements, or other arrangements to provide comprehensive behavioral health prevention and treatment services which emphasizes the management of the costs associated with the provision of specific medical treatments or services in each Area office of the Service; and

“(3) ACCESS TO RECORDS.—The Service shall provide access to patients of the Secretary to health records maintained by, or on behalf of, the Service in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to access to health care records.

“(4) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall authorize to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

“SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated such sums as may be necessary to carry out this title.

“TITLE VII—BEHAVIORAL HEALTH PROGRAMS.

“SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

“(a) PURPOSES.—The purposes of this section are as follows:

“(1) to authorize and direct the Secretary, acting through the Service, to develop a comprehensive behavioral health prevention and treatment program which emphasizes the management of the costs associated with the provision of specific medical treatments or services in each Area office of the Service; and

“(2) to the extent consistent with such regulations, other Federal rules applicable to access to health care records.
“(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and drug abuse, law enforcement, and judicial services.

“(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

“(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop tribal plans and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

“(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

(1) the number of Indians served who are directly affected by such illness or behavior; and

(2) an estimate of the financial and human cost attributable to such illness or behavior.

“(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

“(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to meet their responsibilities under the plans.

“(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, urban Indian organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, urban Indian organization, or the Service.

“(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

“(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

“(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

(B) detoxification (social and medical);

(C) acute hospitalization;

(D) intensive and short-term stay treatment;

(E) residential treatment;

(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

(G) emergency shelter;

(H) intensive case management; and

(I) diagnostic services.

“(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

(C) identification and treatment of co-occurring disorders and comorbidity;

(D) prevention of alcohol, drug, inhalant, and tobacco use;

(E) early intervention, treatment, and aftercare;

(F) promotion of healthy approaches to risk and safety issues; and

(G) identification and treatment of neglect, physical, mental, and sexual abuse.

“(3) FAMILY CARE.—Behavioral health services for family members of prescription, prevention, early intervention, and treatment services, including—

(A) community-based prevention, intervention, and aftercare;

(B) mental health and substance abuse services (emotional, organic, drug, inhalant, and tobacco);

(C) identification and treatment of mental illness and dysfunctional and self-destructive behavior.

“(4) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, organic, drug, inhalant, and tobacco), including sex specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy approaches to managing conditions related to aging;

(E) sex specific treatment for sexual assault and domestic violence.

“(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate with Federal and Tribal organizations to develop and implement of such plan. The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

“(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Improvements Act Amendments of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need.

“(g) ELDER CARE.—The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

“SEC. 702. INDIGENOUS ORGANIZATIONS AND THE DEPARTMENT OF THE INTERIOR.

“(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall each submit to the Committees on Energy and Natural Resources a report on the extent, feasibility, and desirability of the coordination of the existing and additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

“(b) THE RIGHT OF INDIANS.—The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

“(c) THE RIGHTS OF INDIAN TRIBES.—The rights of Indian Tribes, Tribal Organizations, and urban Indian organizations to receive the benefits of such services.

“(d) THE RIGHTS AND RESPONSIBILITIES OF THE BUREAU OF INDIAN AFFAIRS.—The Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization in the development and implementation of such plan. The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.
and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

(6) A strategy for the comprehensive co-ordination of health care services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

(A) a memorandum of understanding of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with the behavioral health initiatives pursuant to this Act, particularly with respect to treatment plans developed and implemented by the Bureau of Indian Affairs and the Service for alcohol and substance abuse program, which shall include, at a minimum, the following:

(i) a community-based treatment plan;

(ii) an enhanced treatment plan for high-risk populations, including pregnant and postpartum women and their children; and

(iii) a clinically based service plan for the purpose of treating the population required under subsection (a).

(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

(8) Providing for an annual review of such agreements by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

(B) Specific Provisions Required.—The memorandum of understanding or agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

(i) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

(ii) an assessment of the existing and needed services for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

(iii) an annual report on the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse; and

(9) and the memorandum of understanding pursuant to which the Service, the Bureau of Indian Affairs, and Service programs and services shall be used to make grants to urban Indian organizations.

(C) Publication.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memorandum, amendments or modifications to each Indian Tribe, Tribal Organization, and urban Indian organization.

SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

(a) In General.—Under the authority of section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412), the Secretary shall establish and maintain a mental health technician program within the Service which—

(i) for the training of Indians as mental health technicians; and

(ii) employs such technicians in the provision of mental health care, including but not limited to identification, prevention, education, referral, and treatment services.

(C) Supervision and Evaluation of Technicians.—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

(D) Traditional Health Care Practices.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the traditional health care practices of the Indian Tribes to be served.

SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

(a) In General.—Subject to the provisions of section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

(b) Waiver.—An individual may be employed as a psychologist, social worker, or marriage and family therapist to provide mental health care services described in subsection (a) if such individual—

(i) is employed by, or under the supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;
"(3) Location.—A youth treatment center constructed or purchased under this subsection may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian Tribe or Tribal Organization operating the program.

(6) Rehabilitation and Aftercare Services.—

"(1) In General.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with the Secretary of the Interior, shall develop and implement each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are facing significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support their transition to their home community.

"(2) Administration.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis intervention and treatment, consultation services with, and medical assistance to Service, tribal, or urban clinics and health services providers working with Indian youths,

"(C) To assist, educate and train community leaders, health education professionals
and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and local State and local health services providers.

(1) suicide prevention;

(2) suicide education;

(3) suicide screening;

(4) suicide prevention; and

(5) ways to mobilize communities with respect to the identification of risk factors for suicide.

(2) For data collection and reporting related to Indian youth suicide prevention efforts.

(3) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian Tribe or Tribal Organization may use and promote the traditional health care practices of the Indian Tribes and for the youth to be served.

(4) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe or Tribal Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) a description of the project that the Indian Tribe or Tribal Organization will carry out using the funds provided under the grant;

(B) a description of the manner in which the project funded under the grant would—

(1) meet the telemental health care needs of the Indian youth population to be served by the project; or

(2) improve the access of the Indian youth population to be served to suicide prevention and treatment services; and

(C) evidence of support for the project from the local community to be served by the project;

(D) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

(E) a plan to involve the tribal community of the youth who are provided services by the project in evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

(F) a plan for sustaining the project after Federal assistance for the demonstration project is terminated.

(5) COLLABORATION; REPORTING TO NATION CLEARINGHOUSE.—(A) The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

(6) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

(A) describes the number of telemental health services provided under this section, including any data available which indicates the number of attempted suicides;

(B) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

(C) evaluates whether the demonstration project should—

(1) be expanded to provide more than 5 grants; and

(2) be designated a permanent program; and

(D) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

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

SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

Not later than 1 year after the date of enactment of the Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units.

SEC. 710. TRAINING AND COMMUNITY EDUCATION.

(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian Tribes and Tribal Organizations to develop and implement, within each Service Unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such programs shall include education about behavioral health issues to political leaders, Tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such programs may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and education.

(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including prevention, intervention, and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel of schools or programs under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 2 of the Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

(3) community-based and multidisciplinary strategies, including Systems of Care for preventing and treating behavioral health problems.

SEC. 711. BEHAVIORAL HEALTH PROGRAM.

(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria—

(1) The project will address significant unmet behavioral health needs among Indians.

(2) The project will serve a significant number of Indians.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

(5) The project may deliver services in a manner consistent with traditional health care practices.

(6) The project is coordinated with, and avoids duplication of, existing services.

(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

SEC. 712. FETAL ALCOHOL DISORDER PROGRAM.

(a) PROGRAMS.—(1) IN GENERAL.—The Secretary, consistent with section 701 and acting through the Service, is authorized to establish and operate fetal alcohol disorder programs as authorized by this section for the purposes of meeting the health status objectives specified in section 3.

(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

(1) To develop and provide for Indian community and in-school substance abuse education, and prevention programs relating to fetal alcohol disorders.

(2) To identify and provide behavioral health treatment services to high-risk Indian women and high-risk women pregnant with an Indian’s child.
“(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected Indians and their families; and

(iv) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

(c) Prevention and intervention models—

(1) The Prevention and Intervention Task Force shall be composed of representatives of traditional health care practices, cultural values, and community involvement.

(2) The Development, print, and disseminate education and prevention materials on fetal alcohol disorder.

(vii) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

(b) Additional uses—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

(i) Early childhood intervention projects from birth to age 3 designed to mitigate the effects of fetal alcohol disorder among Indians.

(ii) Community-based support services for Indians and women pregnant with Indian children.

(iii) Community-based housing for adult Indians with fetal alcohol disorder.

(c) Criteria for applications—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

(b) Services—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall:

(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in tribal communities; and

(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

(c) Task force—The Secretary shall establish a task force to be known as the Fetal Alcohol and Other Drugs Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

(1) the Secretary of the Treasury.

(2) The National Institute on Alcohol and Alcoholism.

(3) The Office of Substance Abuse Prevention.

(4) The National Institute of Mental Health.

(5) The Service.

(6) The Office of Minority Health of the Department of Health and Human Services.

(7) The Administration for Native Americans.

(8) The National Institute of Child Health and Human Development (NICHD).

(9) The Centers for Disease Control and Prevention.

(10) The Bureau of Indian Affairs.

(11) Indian Tribes.

(12) Tribal Organizations.

(a) Domestic and Sexual Violence Prevention and Treatment Programs—

(1) In general.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian Health Programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs and services for victims of domestic violence and sexual abuse.

(b) Report.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

(3) Training and Certification—

(a) In general.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

(4) Coordination—

(1) In general.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian Health Programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs and services for victims of domestic violence and sexual abuse.

(b) Report.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.
child-centered, family-focused and family-driven, community-based, and culturally competent and responsive to the needs of the children and families being served. The systems care approach involves prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive wraparound services, individualized service planning, services in the least restrictive environment, and integrated services with coordinated planning across the child-serving systems.

**SEC. 717. AUTHORIZATION OF APPROPRIATIONS.**

"There is authorized to be appropriated such sums as may be necessary to carry out the provisions of this title.

**TITLE VIII—MISCELLANEOUS**

**SEC. 801. REPORTS.**

"For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall transmit to Congress a report containing the following:

(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population.

(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and ascertain that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and urban Indian organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 807.

(3) A report on the use of health services by Indians—

(A) on a national and area or other relevant geographical basis;

(B) by gender and age;

(C) by source of payment and type of service;

(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

(E) provided under contracts.

(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(m).

(6) A report of the findings and conclusions of demonstration programs on development of integrated health care systems and promotion of preventive health care services, including substance abuse counseling as required in section 125(f).

(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

(9) A report of services incorporated to Congress on infectious diseases as required by section 212.

(10) A report on environmental and nuclear health hazards as required by section 215.

(11) An annual report on the status of all health care facilities needed as required by section 301(c)(2)(B) and 301(d).

(12) A report on the existence and sanitary waste disposal facilities as required by section 302(h).

(13) An annual report on the expenditure of non-Services for renovation as required by section 304(b)(2).

(14) A report identifying the backlog of medical and repair required at Service and tribal facilities required by section 313(a).

(15) A report providing an accounting of renovation funds required by the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

(17) A report on evaluation and renewal of urban Indian programs under section 505.

(18) A report on the evaluation of programs as required by section 513(d).

(19) A report on alcohol and substance abuse as required by section 701(f).

(20) A report on Indian youth mental health services as required by section 707(h).

(21) A report on the reallocation of base resources if required by section 807.

(22) A report on the movement of patients between Service Units, including—

(A) a list of those Service Units that have a net increase and those that have a net decrease in the number of patients served; and

(B) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

(23) A report on the extent to which health care facilities in the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.

**SEC. 802. REGULATIONS.**

"(a) DEADLINES.—

(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to carry out such regulations as the Secretary may promulgate such regulations or amendments thereto that are necessary to carry out this Act, except sections 105, 115, 117, 202, and 409 thereof. The Secretary shall publish in the Federal Register final regulations to implement this Act, except sections 807.

(2) RECORDS.—The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes, Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes and Tribal Organizations from each Service Area.

(c) PROPOSED REGULATIONS.—The Secretary shall submit the negotiated rulemaking procedures to the unique context of
self-governance and the government-to-gov-ernment relationship between the United States and Indian Tribes.

'(d) Lack of Regulations.—The lack of promulgated regulations shall not limit the effect of this Act.

SEC. 803. PLAN OF IMPLEMENTATION.

(a) In General.—Not later than 1 year after the enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Native organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. The implementation plan shall be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(b) Lack of Plan.—The lack of (or failure to submit) such a plan shall not limit the effect, or prevent the implementation, of this Act.

SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED TO INDIAN HEALTH SERVICES.

Any limitation on the use of funds contained in an Act providing appropriations for the period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing for the performance of abortions under section 300a-6 of title 42, United States Code.

SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.

(a) In General.—The following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian Tribe;

(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant has been determined to be a descen-dant of, the health resources of the Service. If any such individual is determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of determination of competency.

(b) Spouses.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of the Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining need for, or allocation of, its health resources.

(c) Provision of Services to Other Individuals.—

(1) In General.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

(B) the Secretary and the served Indian Tribes have jointly determined that—

(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

(2) ISDEAA Programs.—In the case of health programs and facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian Tribe or Tribal Organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract to individuals who are not eligible for such health services under law, amounts collected under this section or under any other provision of law. In making such determinations, the governing body of the Indian Tribe or Tribal Organization shall take into account the considerations described in paragraph (1)(B).

SEC. 806. HEALTH SERVICES FOR INELIGIBLE PERSONS.

(a) Children.—Any individual who—

(1) has not reached 19 years of age;

(2) is the natural or adopted child, step-child, foster child, legal ward, or orphan of an eligible Indian; and

(3) is regarded as an Indian by the community in which such descendant lives.

(b) Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the Service area under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Clarification.—Nothing in this section, as expanded to include the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

SEC. 807. REALLOCATION OF BASE RESOURCES.

(a) Report Required.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be incorporated only in an agreement that has been submitted to Congress, under section 801, a report on the proposed change in allocation of the Service, including the reasons for the change and its likely effects.

(b) Exception.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is 5 percent less than the amount appropriated to the Service for the previous fiscal year.
such agency or organization to perform liability for such participation or for providing such information if the participation or provision of information was in good faith based on the reasonable belief that the time the medical quality assurance program activity took place.

(b) Application to Information in Current Quality Assurance Records. — The section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient’s medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

(2) Regulations. — The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

(D) Definitions. —

(1) The term ‘health care provider’ means any health care professional, including certified or licensed health aides, who is certified to perform health care services.

(2) The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of this Act by or for an Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, licensing, credentialing, or the monitoring of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(3) The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of this Act by or for an Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, licensing, credentialing, or the monitoring of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(4) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality to protect the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(5) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality to protect the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(6) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality to protect the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(7) Disclosure for Certain Purposes. —

(1) In General. — Nothing in this section shall be construed as authorizing or requiring the disclosure of any entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organization’s medical quality assurance program.

(2) Withholding from Congress. — Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

(e) Prohibition on Disclosure of Record or Testimony. — A person or entity having possession of any medical quality assurance record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

(f) Exemption from Freedom of Information Act. — Medical quality assurance records described in any section of this Act may not be made available to any person under section 552 of title 5, United States Code.

(g) Limitation on Civil Liability. — A person who participates in providing information to a person or body that reviews or creates medical quality assurance records described in subsection (a) for a medical quality assurance program, or on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

(h) Continuation of Protection. — Disclosure under subsection (c) does not permit re-disclosure except to the extent the further disclosure is authorized under subsection (c) or is otherwise authorized to be disclosed under this section.

(i) Inconsistencies. — To the extent that the protections under the Patient Safety and Quality Improvement Act of 2005 and this section are inconsistent, the provisions of whichever is more protective shall control.

(j) Relationship to Other Law. — This section shall continue in force and effect, except as otherwise provided in any Federal law enacted after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.
for the purposes of section 1151 of title 18, United States Code.

**SEC. 814. SENSE OF CONGRESS REGARDING LAW ENFORCEMENT AND METHAMPHETAMINE USE IN INDIAN COUNTRY.**

“It is the sense of Congress that Congress encourages State, local, and Indian tribal law enforcement agencies to enter into memoranda of agreement between and among those agencies for purposes of streamlining law enforcement activities and maximizing the use of limited resources—

“(1) to improve law enforcement services provided to Indian tribal communities; and

“(2) to increase the effectiveness of measures taken to restrict the availability of methamphetamine use in Indian country (as defined in section 1151 of title 18, United States Code).

**SEC. 815. PERMITTING IMPLEMENTATION THROUGH CONTRACTS WITH TRIBAL HEALTH PROGRAMS.**

“Nothing in this Act shall be construed as preventing the Secretary from—

“(1) carrying out any section of this Act through contracts with Tribal Health Programs; and

“(2) carrying out sections through 214, 701(a)(1), 701(b)(1), 701(c), 701(g), and 712(b), through contracts with urban Indian organizations.

The previous sentence shall not affect the authority the Secretary may otherwise have to carry out other provisions of this Act through such contracts.

**SEC. 816. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.**

“(a) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

“(b) Limitation on New Spending Authority.—Nothing in this Act is authorized to be spent unless specifically authorized in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93–344, 88 Stat. 3171) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

“(c) Availability.—The funds appropriated pursuant to this Act shall remain available until expended.”.

**SECTION 817. RATE OF PAY FOR OFFICIALS IN INDIAN HEALTH SERVICE.**

(1) POSITIONS AT LEVEL IV.—Section 3515 of title 5, United States Code, is amended by striking “Assistant Secretaries of Health and Human Services (7)” and inserting “Assistant Secretaries of Health and Human Services (7)”.

(2) POSITIONS AT LEVEL V.—Section 3516 of title 5, United States Code, is amended by striking “Director, Indian Health Service, Department of Health and Human Services”. (c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

“(1) Section 3307(b)(1)(C) of the Children’s Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

“(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

“(A) in section 3 (25 U.S.C. 3902)—

“(i) by striking paragraph (2);

“(ii) by redesigning paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

“(iii) by inserting before paragraph (4) (as redesignated by clause (ii)) the following:

“(3) ASSISTANT SECRETARY.—The term ‘Assistant Secretary’ means the Assistant Secretary for Indian Health.”

“(B) in section 3 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

“SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH;

“(c) by striking the subsection heading, by striking “Director” and inserting “Assistant Secretary”; and

“(E) by striking “Director” each place it appears and inserting “Assistant Secretary”.

“(3) Section 550(h)(2) of the Augustus F. Hawkins-Dowd Elementary and Secondary School Improvement Amendment of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

“(4) Section 230(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763a(a)(1)) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

“(5) Subsections (b) and (e) of section 518 of the Comprehensive Drug Abuse Prevention and Control Act (28 U.S.C. 1377) are amended by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”; and

“(6) in paragraph (2)(A), by striking “the Directors referred to in such paragraph” and inserting “the Director of the Centers for Disease Control and Prevention”.

“(8) Subsections (b) and (e) of section 518 of the Employment Act (29 U.S.C. 1378) are amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

“(9) Subsection (d) of section 518 of the Employment Act (29 U.S.C. 1379) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

“(10) Section 152(l) of the Safe Drinking Water Act (42 U.S.C. 300j–12(1)) is amended by striking “the Secretary of the Interior” and inserting “the Director of the Indian Health Service”.

“(11) Section 893(d)(1) of the Native American Health and Wellness Foundation Act of 1994 (42 U.S.C. 2991b–2(d)(1)) is amended by striking “the Secretary of the Interior” and inserting “the Director of the Indian Health Service”.

**SEC. 3102. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.**

(2) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

(3) DUTIES.—The Foundation shall—

“(1) encourage, accept, and administer private gifts of real and personal property, and income from such gifts, for the benefit of, or in support of, the mission of the Service;

“(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

“(3) participate with and assist Federal, State, local, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

**SECOND.** COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

“(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

“(2) POWERS.—The Secretary may, by and with the advice and consent of the Board, delegate to the Committee any of the powers of the Secretary under this title.

**SECTION 818. REVOCATION DEFAULT.**

“The Secretary shall have the power to revoke the trust status of any tribe or tribal group when the tribe or tribal group fails to meet any of the obligations specified in this Act.
office of the members shall be as provided in the constitution and bylaws of the Foundation.

"(B) REQUIREMENTS.—

(1) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board shall be appointed by the Secretary—

(i) shall be by the Committee not later than 180 days after the date on which the Foundation is established; and

(ii) shall have staggered terms.

(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

"(h) OFFICERS.—

(1) IN GENERAL.—The officers of the Foundation shall be—

(A) a secretary, elected from among the members of the Board; and

(B) any other officers provided for in the constitution and bylaws of the Foundation.

(2) CHIEF OPERATING OFFICER.—The secretary of the Foundation may serve at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

(4) SELECTION (a) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

(b) may adopt and alter a corporate seal;

(c) may enter into contracts;

(d) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

(e) may sue and be sued; and

(f) may perform any other act necessary and proper to carry out the purposes of the Foundation.

(5) PRINCIPAL OFFICE.—

(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

(6) ACTIVITIES: OFFICERS.—The activities of the Foundation may be conducted, and officers may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

(7) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

(i) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

(3) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed the percentage described in paragraph (2) of the sum of—

(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

(B) donations received from private sources during the preceding fiscal year.

(2) PERCENTAGES.—The percentages referred to in paragraph (1) are—

(A) for the first fiscal year described in that paragraph, 15 percent; and

(B) for the following fiscal year, 10 percent.

(3) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funding.

(4) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not be considered an officer, employee, or agent of the United States.

(5) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

(6) FUNDING.—

(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (a)(1) $500,000 for each fiscal year, as subject to budgetary limitation in the Consumer Price Index for all-urban consumers published by the Department of Labor.

(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

"SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

(1) may provide personnel, facilities, and other administrative support services to the Foundation;

(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board;

(3) shall require and accept reimbursements from the Foundation for—

(A) services provided under paragraph (1); and

(B) funds provided under paragraph (2).

(3) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

(5) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

(1) are available; and

(2) are provided on reimbursable cost basis.

(6) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bb, 458bb-1, 458bb-2) as sections 511, 512, and 513, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking “section 501” and inserting “section 701.”

"SEC. 3103. GAO STUDY AND REPORT ON PAYMENTS FOR CONTRACT HEALTH SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States (as referred to in this section as the “Comptroller General”) shall conduct a study on utilization of health care furnished by health care providers under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian Tribe, or a Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for such health care through other public programs and in the private sector;

(B) barriers to access to care under such contract health services program, including, but not limited to, barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under such program;

(C) the adequacy of existing Federal funding for health care under such contract health services programs; and

(D) any other items determined appropriate by the Comptroller General.

(3) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations regarding—

(1) the appropriate level of Federal funding that should be established for health care under the contract health services program described in subsection (a)(1); and

(2) how to most efficiently utilize such funding.

"TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

"SEC. 3201. EXPANSION OF PAYMENTS UNDER MEDICARE, MEDICAID, AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.

(a) MEDICAID.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) by amending the heading to read as follows: “SEC. 1911. INDIAN HEALTH PROGRAMS.”;

and

(B) by amending subsection (a) to read as follows:

“(A) ELIGIBILITY FOR PAYMENT FOR MEDICAL ASSISTANCE.—An Indian Health Program is eligible for payment for residual assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Program if the funding of such assistance includes the conditions and requirements which are applicable generally to the furnishing of items and services under such State plan or waiver authority.”.

(2) REPEAL OF OBSCURE PROVISION.—Subsection (b) of such section is repealed.

(3) RECLASSIFICATION OF AUTOMATED DATA AGREEMENTS.—Section (c) of such section is amended to read as follows:
IHS FACILITIES.—For provisions relating to improvements made under this title, see section 401(d) of the Indian Health Care Improvement Act.

DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.

CONFORMING AMENDMENTS.—Such section is further amended—

(1) in subsection (e)(3), by striking “Subsection (b) and section 401(b)(1) of the Indian Health Care Improvement Act”;

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

(3) by striking subsection (f).

DEFINITIONS.—Such section is further amended by redesigning subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

“(f) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance under this title.

(4) CROSS-REFERENCE TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—Such section is further amended by striking subsection (d) and adding at the end the following new subsection:

“(d) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.”

SEC. 3204. ANNUAL REPORT ON INSURANCE SERVED BY SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1323-b), as amended by the sections 2303 and 2304, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

“(e) ANNUAL REPORT ON INSURANCE SERVED BY HEALTH BENEFITS PROGRAMS FUNDED UNDER THIS ACT.—Beginning January 1, 2011, and thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

“(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

“(2) The number of Indians described in paragraph (1) that also receive benefits under programs funded by the Indian Health Service.

“(3) General information regarding the health status of the Indians described in paragraph (1), disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“A detailed statement of the status of facilities of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization with respect to facilities’ compliance with applicable conditions and requirements of titles XVIII, XIX, and XXI, and in the case of title XIX or XXI under a State plan under such title or under waiver authority, and of the progress being made by such facilities (under plans submitted under 1111(b) or otherwise) toward the achievement and maintenance of such compliance.

“(5) Such other information as the Secretary determines is appropriate.”.

SEC. 3205. DEVELOPMENT OF RECOMMENDATIONS TO IMPROVE THE COORDINATION OF MEDICAID AND SCHIP COVERAGE OF INDIAN CHILDREN AND OTHER CHILDREN WHO ARE OUTSIDE OF THEIR STATE OF RESIDENCY BECAUSE OF EDUCATIONAL NEEDS.

(a) STUDY.—The Secretary shall conduct a study to identify barriers to interstate coordination of enrollment and coverage under the State Children’s Health Insurance Program under title XXI of such Act of children who are eligible for medical assistance or are entitled to such assistance under such programs and who, because of educational needs, migration of families,
emergency evacuations, or otherwise, frequently change their State of residency or otherwise are temporarily present outside of the State of their residency. Such shall be considered for the enrollment and coverage coordination issues faced by Indian children who are eligible for medical assistance or child health assistance under such a plan. Members of their State in residence and who temporarily reside in an out-of-State boarding school or peripheral dor- fums by the Bureau of Indian Af- fairs.

From Michigan (Mr. Camp), the gen-

eral from Texas (Mr. WAXMAN), the gentleman from Minnesota (Mr. Stupak) or his designee, shall be considered read, and shall be debatable for 20 minutes, equally divided and controlled by the proponent and an opponent. The further amendment in the nature of a substi- tute printed in part D of the report, if offered by the gentleman from Michigan (Mr. Stupak) or his designee, shall be considered read, and shall be debatable for 20 minutes, equally divided and controlled by the proponent and an opponent.

The gentleman from California (Mr. Waxman), the gentleman from Texas (Mr. Barton), the gentleman from New York (Mr. Angel), the gentleman from California (Mr. George Miller), and the gentleman from Minnesota (Mr. Klein) each will control 40 minutes.

The Chair now recognizes the gent- leman from California (Mr. Waxman).

Mr. Waxman. Mr. Speaker, I am pleased to start off the debate by rec-ognizing our very distinguished major- ity leader, STENY HOYER from the State of Maryland, for 1 minute.

Mr. HOYER. I thank Mr. Waxman for yielding.

Our rule was chaired by JOHN DIN- GELL, himself a historic figure on a his- toric day.

I want to congratulate all of those who have participated in the accom- plishment of this product that we are con- sider this day: Mr. Waxman, one of our senior Members in the House; Mr. Ran- gel, one of our senior Members in the House; and Mr. Miller.

I want to thank to the Republicans who engaged in this discussion, in this debate, because it is historic, and all of us who sit in this Chamber know that it will have a great effect on our people. Some perceive that effect as not positive. More, I believe, think it is positive. Many of us believe that it is not extraordinarily im-

portant.

Soon each one of us is going to look into his or her conscience and vote on this bill. And when the time comes, I don’t think any of us will sway any of you. But I know that the most powerful arguments for the bill won’t be spoken on this floor. They are being lived right now in our country in every one of our districts, in every one of our towns and counties and munici- palities.

In the anxiety of the family that finds itself paying more and more each year for health insurance that grows weaker and weaker. In the frustration of the small busi-

ness owner weighing the choices of dropping her employees’ coverage against the threat of being driven out of business by her competitors.

And in the fury of the patient who learns that an insurance company bureau-
crat has deemed him too sick for the coverage he paid for.

They are our families, our neighbors, our fellow citizens. They are waiting for health insurance reform that is more predictable, more just. Their stories will be with me and I know with each of us when we cast our vote.

Because I want to say to every Amer-

ican facing down illness: never again, never again will you be denied cov-

erage because you have diabetes or asthma or some other disease or be-

cause you’re pregnant or because you have anything else your insur- er decides is a preexisting condition. Never again will your coverage run out. Nor will you find the coverage you thought you had paid for was actually not there at all. And never again can insurance companies drive out competition and set premiums as high as they like, because there will be a public insurance option and a transparent marketplace to keep them honest, to keep them competitive, to bring prices down.

I want to say to our middle class families, the backbone of our country: you will have health care you can depend upon. Even if you change your job or lose your job or decide to start a business, you will be able to find af-

ordable coverage in a competitive marketplace, an insurance exchange that offers you a choice of good policies at fair rates. In fact, according to an MIT analysis, buying coverage on the exchange will bring your premiums down by a great deal, even without the affordability credits.

If your family makes $90,000 or more, you’ll save more than $1,200 bucks. If your family makes $60,000, you’ll save more than $5,000. And if your family is making $38,000, you’ll save more than $9,000. That’s the kind of tax cut that America needs to secure its medical fu-

ture.

I want to say to our seniors: you can count on Medicare, on a Federal pro-

gram, for dignity and peace of mind in your golden years. And that will not change. Today we had to protect your access to your doctor, to encour-
ge medicare physicians to cooperate on higher quality care, to keep your Medicare solvent for longer, and to bring an end to the doughnut hole that leaves prescription drugs unaffordable for so many.

I want to say to our small business-

men and women: I know your pre-
miums keep going up and that each year they make it harder to stay in business, to compete with Big Business and with foreign firms. You deserve a fair playing field; and in the insurance exchange marketplace, you’ll be able to buy coverage at the low group rates you’re now being denied.

I want to say to the 35 million Amer-

icans without insurance, who are forced to skip checkups and preventa-
tive care, who are forced to turn to the ER as the first and only line of defense, who live sicker and shorter lives: you can look forward to what every man, woman, and child has in every other industrialized country in the world: health coverage you can afford and that you can count on.

And every American who is rightly worried about our mounting deficits and debt, I can tell you this: this bill does not add to the deficit over the next 10 years or the 10 years thereafter. This bill means health care that is more fiscally sustainable for years to come.

This is what this bill, the Affordable Health Care for America Act, can achieve for our country and for our people. It isn’t a simple bill. It isn’t a perfect bill, but it is the product of months and months of debate, sometimes animated debate, yes, even angry debate, careful scrutiny, hard work, and citizen input. And it’s the right response to this time of economic insecurity in which we have been called to lead.

If we miss this chance, or if we vote for a Republican plan that does very little to expand coverage, weakens insur-

ance, frankly, for millions who have it, and continues to allow millions of Americans to be denied affordable cov-

erage, we’ll find ourselves back here again.

But by then, premiums will eat up even more of our families’ budgets; health care will consume even more of our economy; and even more Amer-

icans will have died for the lack of health care.

If we miss this chance, if we miss this challenge of nearly a century’s dura-

tion, when Teddy Roosevelt, one of the great Presidents of this country, a Re-
publican President of this country, said a hundred years ago we need to have health care coverage for all Amer-

icans—this is not a new idea, but it is
an idea whose time has surely come—the years between this chance and our next one will be filled with stories that are unworthy of America at its best.

Stories like Linda’s, who wrote to The New York Times of the anguish she felt suffering from abdominal cancer and the hospital that kept her away from the drugs that could help save her life, drugs her insurance company was denying her.

Stories like Deamonte Driver’s from Prince George’s County, just a few miles down the road, who died at the age of 12 from a toothache, a toothache that was not treated by a dentist; and, as a result, it became infected. That infection went into his brain. He was in the hospital for 30 days at a cost of $290,000. Why? Because he didn’t have $80 to get that tooth filled.

This bill will change that. We can be better than that. America is better than that. We must be.

Americans rightfully want to know what’s in this bill for them and for their families, but there’s also something important in this bill for us as a people: a system worthy of the values we profess and the principles we hold dear. We will vote for a healthier America and the right to give our fellow citizens a greater sense of security. We will vote to make Medicare stronger for our seniors. We will vote for a healthier economy, for affordable coverage for individuals and small business. We will vote to begin containing costs, which will otherwise be unsustainable for our children and for our grandchildren.

We will, in sum, my colleagues, on this historic day, vote for a more perfect Union of which our Founders dreamed.

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 2 minutes.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 3 minutes to a member of the committee, the gentleman from Illinois (Mr. SHIMKUS).

Mr. SHIMKUS. Mr. Speaker, I think it’s right that we set up a health choice administration that sets what the health plans have to be. I don’t think it’s right that you mandate to employers to provide health care insurance; they’re going to pay all these penalties. I don’t think it’s right that we have on occasion had to mandate our young men, and now our young women, to have to serve. We mandate we have to pay our taxes. But we don’t have to mandate that you need health care.

Vote “no” on the bill and “yes” on the Republican substitute.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 3 minutes to the majority whip of the House of Representatives, Mr. CILIBURN.

Mr. CILIBURN. I thank Chairman WAXMAN for yielding me the time.

Mr. Speaker, today I’m thinking about a woman from South Carolina. A few months ago during the August break I participated in a talk radio program on health reform, and a gentleman called in to tell me that his health care was great, and he didn’t want me or the government to mess with it.

I explained to him that our plan was about choice, bringing down costs, and providing quality care. But the next caller got right to the heart of the matter. She said, Of course he likes his health insurance; it is probably because he has never tried to use it. She explained that she had recently been diagnosed with cancer and thought she liked her coverage until she tried to use it. She said that when she began to get treatment she was dropped from her insurance coverage.

Mr. Speaker, that’s why we are here today, to respond to that caller and others who have asked, What’s in this plan for me?

When this bill is signed into law, 15 reforms will immediately occur. Among them are: beginning to close the doughnut hole by increasing Medicare part D coverage by $500; increased funding for community health centers, doubling the number of patients seen over 5 years; extending coverage for young people to stay on their parents’ insurance plans up to their 27th birthday; access for the uninsured with pre-existing conditions to a temporary insurance plan that we are calling a high-risk pool; from the date of enactment and until the exchange is available, uninsured will be prohibited from dropping your coverage if you get sick; from the date of enactment, COBRA health insurance coverage will be extended until the exchange is available and displaced workers can have affordable coverage; and from the date of enactment, we will hinder price-gouging with sunshine requirements on insurance companies to disclose insurance rate increases.

Now, after 2013, when the mandate for coverage and exchange are in place, see these additional protections: no more copays for routine checkups and preventive care; no lifetime or yearly caps on what insurance companies will cover; there will be yearly caps on your out-of-pocket expenses; and, as has been said so often, there will be an end to discrimination because of preexisting conditions like diabetes, heart disease or cancer.

Mr. Speaker, these are just 11 reasons to support this bill. My colleagues will share with you many more.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a member of the committee, the gentleman from Illinois (Mr. SHIMKUS).

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

Mr. SHIMKUS. Mr. Speaker, I think it’s right that we have on occasion had to mandate our young men, and now our young women, to have to serve. We mandate we have to pay our taxes. But we don’t have to mandate that you need health care.
government-controlled system. Don’t trust me; ask my friend, JAN SCHAKOWSKY, or ask Chairman BARNEY FRANK. Or believe President Obama who said, “I happen to be a proponent of a single-payer health care program. But I don’t think we’re going to be able to eliminate employer coverage immediately.”

Make no mistake, this bill will achieve the single-payer goal. And along with it, it will raise premiums, increase taxes, cuts billions of dollars from Medicare, and cost millions of working Americans their job. And at the end, a single-payer system will force every American into a one-size-fits-all system that rations care. A government that rations care is anti-life.

Mr. WAXMAN. Mr. Speaker, at this time I am very pleased to recognize and to yield 1 minute to the gentlewoman from Connecticut (Ms. DeLAURO).

Ms. DeLAURO. Mr. Speaker, I rise at this historic moment in support of the Affordable Health Care for America Act. None of us will again have such an opportunity in our time serving in the United States Congress to do something so enduring and fulfilling to make sure that every American shall have access to quality, affordable health insurance.

For more than a century, the special interests have won this moment. Presidents Theodore Roosevelt, Franklin, Kennedy, Nixon, and Clinton have spoken of our country’s aspiration, but only now have we come so far. When the Democrats and the Congress passed Medicare, we lifted seniors out of poverty forever, and now we get to say to working Americans, You can no longer be broken by a health insurance system that drops you when you are sick or lose a job.

It says to women, You will no longer be denied coverage on account of a C-section or domestic violence. No longer will maternity or preventive care be ignored.

I urge my colleagues to vote for history and for America today. This is why we are here.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to the gentleman from Connecticut (Ms. BONO MACK), a member of the committee.

Mrs. BONO MACK. Mr. Speaker, I rise today to express my strong opposition to this bill. It is a bill that flies in the face of the Democratic oath which both my father and grandfather took as young doctors, which says, “Do no harm.”

In fact, this bill does a tremendous amount of harm and would inflict an enormous burden on current and future generations of Americans. It would raise insurance premiums, raise taxes, and create huge new government bureaucracies to stand squarely between patients and their doctors.

This bill does not offer real health care reform. Rather than reduce costs and make health care more affordable and accessible, this bill will increase costs to consumers and put the government in charge of determining what treatment and care Americans are entitled to.

Millions of Americans have resoundingly rejected this shell game masquerading as reform. The very least we can do is listen to the American people and reject this flawed bill.

Mr. WAXMAN. Mr. Speaker, I am pleased now to yield 2 minutes to the gentleman from Connecticut (Mr. LARSON), the chairman of the Democratic Caucus.

Mr. LARSON of Connecticut. Mr. Speaker, I thank Mr. WAXMAN and Mr. RANGEL and Mr. MILLER for their help.

The growth of this great Nation cannot be achieved without caring for the health of its citizens. Thirty-six million Americans who said, “I happen to be a proponent of a single-payer health care program.”

The same fear was spread during the debate on Social Security and Medicare. Today, we will put a stop to the fear and address the real threat, the real danger the American people face. The woman next to you on the train spreading the flu because she couldn’t afford to see a doctor. The little boy in the sandbox with your child whose parent couldn’t afford the vaccinations.

And if we have learned anything from the H1N1 epidemic, the billions of dollars these public health emergencies cost all of us, and that disease has no boundaries or borders; it affects all of us.

On this historic day, this Congress will pass what will improve both the fiscal and physical health of the entire Nation by improving health care for all of our citizens. It is a statement of our values. It is testimony to how we care for our fellow citizens. It is at the very core of all that America stands for and what America is about. Thirty-six million Americans deserve nothing less.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. DEAL), a subcommittee ranking member.

Mr. DEAL of Georgia. Mr. Speaker, I rise in opposition to this bill, and I express three major concerns.

First of all, I raise a question. The question is, who has authority in the United States Constitution gives this Congress the right to mandate that every citizen must purchase a health insurance policy, and upon failing to do so, shall be fined and possibly imprisoned? I think the answer to that question is, there is no such congressional authority.

Secondly, make no mistake about it, illegal aliens will receive government-paid health care because all they are required to show is a Social Security number and a name. There is no way to prevent the same Social Security number from being used by numerous individuals, and there is no requirement that a picture ID be produced in order to prove that the person is in fact the name that appears on the Social Security card. If you think identity theft is a problem now, just wait until this bill passes.

Thirdly, this bill requires States to increase their Medicaid rolls to 150 percent of the Federal poverty level. In an ever-increasing fashion, States will have to absorb the cost of this burden. I offered an amendment which would have allowed States to opt out of this mandate, but it has been rejected. In States like mine, where we have to balance our budget, right now schoolteachers and law enforcement officers are having to take unfunded furlough days. If this bill passes, it will only make things worse. We are voting on a bill that takes days and money out of the paychecks of teachers and law enforcement officers to pay for this piece of legislation.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from the State of Maryland, Mr. CHRIS VAN HOLLEN.

Mr. VAN HOLLEN. Mr. Speaker, today our Nation stands at an historic crossroads. We can choose the road that dead-ends in the status quo where the health industry will continue to call the shots and ration our health care or we can pass this bill and take the path that will provide every American citizen access to quality, affordable health care.

What we do in this bill is preserve what is best and fix what is broken. We can cut through the skyrocketing health care costs that are breaking our family’s budget, forcing businesses to drop health insurance, and will eventually bankrupt our Nation. We saw health insurance premiums more than double between 2000 and 2008, and during that period of time, health insurance profits soared by 500 percent. How did they do it? Essentially by saying “no” to people who had preexisting conditions and using the fine print in insurance policies to deny people promised benefits when they needed help the most.

This bill will end those abuses. It ends the antitrust exemption that
Mr. Speaker, that’s why the Consumers Union and Consumer Reports support this legislation. That’s why the AARP, the largest organization protecting the rights of seniors, has endorsed this. And that’s why the doctors of America have endorsed this.

I understand why the insurance industry opposes this bill, but our job is not to protect the special interests of the insurance industry; our job is to do what’s right by the American people.

Let’s move this country forward.

Let’s vote “yes” for America.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to another member of the committee, Congresswoman MARSHA BLACKBURN of Nashville, Tennessee.

Mrs. BLACKBURN. Mr. Speaker, I find it so interesting that some are so excited about voting for this bill. Quite frankly, I find it to be a very sad day that this body would take a step moving toward a single-payer system in health care.

We have all heard the horror stories of what happens in Europe and in Canada as women seek to get care for breast cancer and die before that care can be found, because care delayed is care denied. We have heard about heart surgeries that never came to pass because they were waiting in the queue. We have talked to mothers who sought desperately to have children treated for chronic illnesses and could not get that help. We have heard about our seniors, and we know what this bill will do to Medicare, making one-half trillion dollars worth of cuts. We have talked to mothers who have said, My goodness, you cannot even get H1N1 vaccine out there and you think you’re going to handle the health care for my children?

And today, recorded in the Wall Street Journal, Betsy McCaughey, former Lieutenant Governor of New York, cites some of the provisions and what it will do to the seniors in this Nation as it cuts into their access.

This is not the action we should take.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The time of the gentleman has expired.

The Speaker would ask all Members to adhere to the time limits and to heed the gavel.

Mr. WAXMAN. Mr. Speaker, I yield myself 3 minutes.

Today, we have a historic opportunity. Sixty-five years after Franklin Roosevelt and Social Security and 35 years after Medicare, we have an opportunity, under the leadership of President Obama and Speaker Pelosi, to reform our health care system and to last provide coverage to all Americans.

We know that health insurance today is failing our families and our economy. If we do nothing, the system will go bankrupt, premiums will keep skyrocketing, benefits will be slashed, what you get will cost more, and the deficit will increase by billions of dollars.

Today, Americans with health insurance know that they are one serious illness away from debt and bankruptcy, and millions of Americans have no insurance at all. With this legislation, we can fix these problems.

First and foremost, this bill provides health insurance security for all Americans. If you have health insurance today, you can keep it; you keep your doctor and your other health providers. But if you lose your job, you will not lose your health insurance. If you have a preexisting medical condition, you cannot be denied health insurance.

If you have a serious illness, we remove the cap insurance companies have imposed that will cut coverage over your lifetime. Effective immediately, it will be illegal for insurance companies to put lifetime caps on your coverage. And children all the way up to age 27 can continue on their parents’ policies.

Our bill has historic reforms. It expands coverage and reduces costs. It trains doctors and supports community health centers. It provides a public health insurance option that will give Americans more choice and competition.

Our legislation strengthens Medicare. We will eliminate copayments for preventive services. We closed and then eliminated the doughnut hole that makes prescription drugs unaffordable for so many of our seniors.

And this legislation is affordable. The only thing not affordable is to do nothing. The legislation is fully paid for. It will not add to the deficit over the next two decades.

Today, we have the chance of a lifetime to do something great and momentous for the American people. By passing this bill, we can reform health insurance in America and provide all Americans with the security of knowing that when they get sick, care will be affordable and available.

I urge all my colleagues to support this bill.

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

Mr. BARTON of Texas. Mr. Speaker, I yield for an unanimous consent request to the former chairman of the Appropriations Committee, Mr. BILL YOUNG of Florida.

(Mr. YOUNG of Florida asked and was given permission to revise and extend his remarks.)

Mr. YOUNG of Florida. Mr. Speaker, I rise in opposition to the bill.

Mr. Speaker, this bill, H.R. 3962, does not represent good public policy. I rise to express the serious concerns about H.R. 3962, the Affordable Health Care for America Act.

This legislation is misnamed, as even the nonpartisan Congressional Budget Office says it will not be affordable for the American people and our nation as a whole.

The Congressional Budget Office says this legislation will cost $1.055 trillion over the next 10 years, raising taxes on American taxpayers and businesses by $729.5 billion. Of great concern, my friends, and Medicare beneficiaries I represent, is that it will also cut Medicare payments by $500 billion. There is no possible way you can cut such a significant amount of funding out of a program that is so vital to senior citizens without compromising the availability or quality of care without disrupting the relationship they have with their current doctors and medical providers.

Within the Medicare program, H.R. 3962 also cuts the reimbursement rate for seniors enrolled in Medicare Advantage programs. In the 10th Congressional District of Florida which I represent, more than one-third of the Medicare beneficiaries, or 47,729 seniors, are currently enrolled in Medicare Advantage plans. The Chief Actuary of the Centers for Medicare and Medicaid Services estimates that if enacted, the legislation we consider today will cut enrollment in Medicare Advantage by 64 percent over 4 years. This means that more than 30,500 of the seniors I represent will lose or have to give up the health care coverage they currently have and like. This violates the number one promise made by the sponsors of this legislation, who say that if you like your current health care coverage, you can keep it.

The Congressional Budget Office also notes that changes in this legislation to the Medicare Part D program will, in the end, drive up Part D premiums by as much as 4 percent. These additional premiums that seniors living on fixed incomes will have to pay to keep their prescription drug coverage.

Finally, with regard to Medicare, this legislation does nothing to correct a 21 percent cut in physician reimbursement rates that is scheduled to take effect January 1st for doctors who provide care to our seniors. Having met with doctors I represent throughout the past year, I know that one of their major concerns about health care reform is that they be allowed to take larger and larger cuts in Medicare reimbursement rates. These cuts, they say, will make it more and more difficult for them to care for Medicare patients. In the end, many seniors could be forced to find new doctors.

In addition to the impact this legislation would have on senior citizens, I am concerned about the economic impact this legislation will have on those seniors, their children, their grandchildren, and their great grandchildren. H.R. 3962 creates a brand new federal entitlement program at a time when our Nation is struggling to sustain those entitlement programs already on the books. While the Congressional Budget Office says that under a best case scenario the $500 billion in Medicare cuts and $729.5 billion in tax increases will pay for this legislation over its first 10 years if there are much larger productivity costs, it is doubtful that this will keep the program from running up federal deficits after that and leaves no margin for error.

In fact, despite one of the goals of this legislation to make health insurance more available and affordable for uninsured Americans, we simply move an estimated 18 million people into the government Medicaid program. This is more than half of the 34 million uninsured
Americans who the Chief Actuary of the Centers for Medicare and Medicaid Services says will receive coverage under this legislation.

Of the 13 million uninsured Americans who will receive coverage under the Health Insurance Exchange program created in this legislation, estimates that 25 percent, or 5.2 million, will take advantage of the government subsidized public option created by H.R. 3962.

The creation of a government subsidized public option is another major concern of the large majority of my constituents who have called and written me in opposition to this legislation. We are concerned about the insertion of the federal government into the precious patient-doctor relationship. At last count, this 1,990 page bill creates more than 100 new boards, bureaucracies, commissions and programs. Among those created by the bill is the “Health Benefits Advisory Committee,” that would be chaired by the U.S. Surgeon General, to make recommendations on cost and coverage issues.

This 27-member government committee of unelected administrators will be in charge of advising other bureaucrats, who will then decide what procedures American citizens are allowed to have and what doctors you are allowed to see under your healthcare plan. This places another layer of bureaucracy between you and your doctors.

This committee is in addition to another newly created federal organization called the “Health Choices Administration,” which will be governed by a new Commissioner who will distribute billions of dollars of taxpayer-funded subsidies. Additionally, the Commissioner will have complete control over all insurance plans offered through the newly created Health Insurance Exchange.

Perhaps the toughest of the mandates handed down by the federal government under this legislation is that businesses must provide health care for their employees or pay an 8 percent payroll tax and that individuals must purchase health insurance or pay a 2.5 percent tax on their adjusted gross income. This is not the federal government providing incentives to individuals or employers. This is the federal government imposing its will on individuals and businesses, and penalizing those who do not comply.

This legislation further penalizes small businesses by imposing a 5.4 percent surtax on individuals earning more than $500,000. Half of these so-called “high earners” are small business owners. Just imagine how small business owners all across our nation will react to this $544 billion in new federal taxes they will pay over the next 10 years. With the unemployment rate nationally at 10.2 percent and 11.4 percent in Florida, Congress should not be making it harder for business owners to create new jobs.

Finally, at a time when we are trying to lower health care costs, this legislation imposes a new 2.5 percent excise tax on the cost of wheelchair, portable oxygen systems, diabetes testing equipment, and a whole range of other medical devices. This tax will be paid by our constituents who have no choice but to purchase this medical equipment and who may already be stretched thin by other mandates.

Mr. Speaker, I have discussed here some of my concerns about provisions in this bill; however there are glaring omissions to this legislation as well. The most significant provision that has been left out is medical liability reform. This is a top issue for doctors, hospitals and all medical providers, as it is one of the major drivers increasing the cost of health care. Tort reform would help reduce the filing of unfounded lawsuits, decrease the number of duplicative tests like imaging and alternative medicine, and lower the cost of medical malpractice insurance rates, which would translate in lower medical costs.

Tort reform is one of the many areas that we can agree to that would increase the availability and decrease the cost of health care. There are others I support, some in this bill, including requiring coverage for individuals with pre-existing conditions, preventing insurance companies from cancelling the policies of individuals when they become sick, providing for the availability of health insurance across state lines, ensuring that employees can retain access to health insurance when they change or lose their jobs, creating health insurance pools that small business owners and self-employed individuals can join to provide lower cost health insurance for them and their employees and themselves, and closing the so-called doughnut hole in the Medicare Part D prescription drug program.

Mr. Speaker, there is no doubt that our nation can and should do better to provide quality affordable health care for the American people. Throughout my service in Congress, I have done all I could to expand health care opportunities nationally and throughout the 10th Congressional District, which I represent. By establishing the National Marrow Donor Program in 1986, I sought to provide life-saving medical options to terminally ill patients suffering from leukemia and more than 60 otherwise fatal blood disorders. Today the national registry has more than 7 million volunteers available to donate the life-saving bone marrow.

During the time that I worked to establish the national registry and as we began to find matched marrow donors for patients, I met with family after family who needed help convincing health insurance companies to cover the cost of marrow donations. From this experience, I witnessed first-hand the tragedy of families losing their health insurance coverage at their time of greatest need and of being denied coverage for a life-saving procedure.

In a similar manner, I have identified other national and local health care needs and have done something to solve the problems that include increasing the vaccination rates for our nation’s children; ensuring the availability of specialized services, facilities and equipment at our nation’s hospitals to meet the needs of children; expanding the funding for graduate medical education programs to increase the number of doctors who receive the next step of their training; increasing the Inspector General force at federal agencies to uncover waste, fraud and abuse which threaten the safety of seniors and veterans, and divert limited federal health care resources; improving the quality of health care through our investment in biomedical research by doubling the budget for the National Institutes of Health during my 6 years as Chairperson of the Appropriations Committee and expanding other research opportunities through the Department of Defense in the areas of breast cancer, prostate cancer, Parkinson’s Disease, ALS, multiple sclerosis and diabetes; and expanding the number of community health centers throughout Florida and Pinellas County.

Mr. Speaker, I take a back seat to no one when it comes to my work to improve and expand the quality and availability of health care for the American people and the people I represent. I supported the creation under direction of the State Children’s Insurance Program, which increases access to health care for our nation’s youth, and likewise the Family and Medical Leave Act, allowing employees to take time off from work to care for a sick and receiving family member.

However, I cannot support legislation that would threaten the sanctity of the patient-doctor relationship, that would establish new federal bureaucracies that would insert themselves into the health care programs of individuals and employers, that creates a new and financially unsustainable federal entitlement program, that threatens the availability of health care for our nation’s seniors, that raises taxes substantially and threatens the viability of many small businesses at a time when we are trying to get our nation’s economy back on track, and that ultimately will not make health care insurance more affordable for the American people.

We have all heard from the American people we represent over the past few months about this legislation that has been under consideration. We have heard that they are closely following its progress. We have heard that they have many concerns about this legislation before us. And we have heard that they want us to work together in a bipartisan manner to bring down the cost and expand the availability of health care coverage.

Today, we have a historic opportunity to tell the American people we hear their voices. We can commit to them that, on this issue which will affect every single household and business in our nation, we will go back to our respective committees and work together—as Republicans and Democrats; conservatives, moderates and liberals; Blue Dogs and Progressives—to come up with a solution that the American people can support and, most importantly, have confidence will do the job without bankrupting our nation, jeopardizing our economic recovery and violating the free market principles upon which our nation was founded.

Mr. BARTON of Texas. Mr. Speaker, I yield a clock 3 minutes to the minority leader, Mr. BOEHNER. This is not his leadership imperial minute. It is the clock 3 minutes.

Mr. BOEHNER. Let me thank my colleague for yielding.

I will be no surprise to any of you that I rise in opposition to this bill.

One of the issues in this bill that is of concern to Members on both sides of the aisle has to do with the sanctity of life. The Rules Committee made in order an amendment by our colleague from Michigan, Mr. STUPAK, that would continue existing law that no Federal funds will be used for abortion.

While I am grateful that we’re going to have this vote in the House, I want to ask the chairman of the Energy and Commerce Committee, Mr. WAXMAN, if the House does vote, in fact, for Mr. STUPAK’s amendment, if the gentleman will guarantee me that when this bill
comes back from conference, that that language will remain in the bill.

Mr. WAXMAN. If the gentleman would yield.

Mr. BOEHNER. I would be happy to yield.

Mr. WAXMAN. As the gentleman well knows, the decision is not up to one person; it will be up to the con-

ferees. The conferees will have to be 

meeting with the Senate conferees and 

going over a number of positions.

If this amendment is adopted by the 

House, it will be the House position as 

we go into conference. We will have to 

discuss it further, and then we will see 

what will be the result. But no guar-

antee can be made by me or any other 

Member at this time.

There will be an opportunity, as you 

know, to instruct the conferees, which 

reinforces, of course, a particular part 

of the House bill.

Mr. BOEHNER. Reclaiming my time, 

the reason this is up at this point in 

the debate is that, while we are grate-

ful to have this amendment and this 

chance to vote to make sure that tax-

payer funding is not used for abortion—which has been the policy of the 

land for the last 30 years—as the gen-
tleman pointed out, there is no guar-

antee that at the end of the day this 

language will be in the bill.

Now, I've been a chairman of a com-

mittee. I understand that there are no 
guarantees, but that's the whole point 

here. The only reason this amendment 

is allowed to be offered is in order to secure enough votes to try to move this bill through the floor today. I have my doubts about whether this lan-
guage, if it passes, has any chance of 
ever being in the final version of this 

bill.

Mr. WAXMAN. Mr. Speaker, at this 
time, I am honored to yield 2 minutes 
to the gentleman from New Jersey (Mr. 
PALLONE), the chairman of the Health 
Subcommittee on the Energy and Com-

merce Committee.

Mr. PALLONE. Mr. Speaker, I want 
to thank my chairman, Mr. WAXMAN, 
for all his hard work on this bill.

For far too long, our Nation has en-
dured a health care system that is cha-

rotic, costly, and crippling American 

families. In casting our votes today, 
each of us must make a simple choice: Do we want to maintain the broken 
system we currently have or do we want 

to carry this load alone?

And you should ask yourself, first, 

are you in favor of allowing health care 

premiums for American families to 

continue to spiral out of control, forc-
ing them to delay care or drop cov-

erage altogether, or are you in favor of 

providing every American with access 
to affordable and quality health insur-

ance?

Second, are you in favor of more 

American businesses falling into bank-
ruptcy under the weight of medical 
bills, or are you in favor of providing 

every American with the security of 

knowing that they won't go broke if 

they get sick?

Third, are you in favor of more 

American businesses delaying invest-

ments, closing their doors or laying off 

workers because of increasing health 
care costs, or are you in favor of mak-
ing it more affordable for those busi-

nesses to offer health care coverage 

for their workers?

And finally, are you in favor of allow-

ing health insurance companies to 

be able to discriminate against people 

because they are sick, women, or older, 
or are you in favor of putting an end to 

this explicit and immoral form of dis-

crimination that insurance companies 

get away with today?

Mr. Speaker, there are many reasons 
to vote for this bill, but there is really 

only one reason to vote against it, and 

that is to maintain the broken health 
care system we currently have.

If you want to change the system, 

vote “yes”; vote for affordable and 

quality health care for every Amer-

ican.

Mr. WAXMAN. Mr. Speaker, at this 
time, I am honored to yield 2 min-
utes to a member of the Republican 
leadership, Mr. McCArTHY of Cali-

ifornia.

Mr. McCArTHY of California. I 

think from the gentleman's opening 

speech, this is my second term. 

Since being elected by the people of 

California's 22nd District, I am re-

minded about how much things have 

changed.

Three years ago on this date, unem-

ployment was 4.5 percent. Today, the 

unemployment rate has more than dou-
bled to a 26-year high of 10.2. Three 

years ago on this date, the stock mar-

ket was over 12,000. Today, the stock 

market has dropped by 2,000 points. 

Three years ago on this date the cur-
rent House majority promised to 

drain the swamp. Today, the swamp in 

Washington isn't drained; it's overflown.

And 3 years ago on this date, November 

7, 2006, the Democratic Party was vic-

torious in winning control of this 

House.

Today, we are here on the floor to 
vote on a $1 trillion government take-

over that can replace the health insur-
ance that millions of Americans have. 

This is a defining vote for this Con-

gress. We can reject tax increases on 

small business at a time when 2.8 mil-

lion jobs have been lost since the stimu-

lus was signed into law and say yes to 

helping small businesses access more 
affordable health insurance for their 

employees. We can reject the govern-
ment takeover of our health care that 

will increase health insurance costs 

and say yes to saving American fami-

lies up to $5,000 off their current health 
care premiums.

I know that over the last 3 years there 

have been many disappoint-
ments, when the voices of Americans 
have been overruled by government 
bailouts and now a government take-

over of health care, but I urge my col-

leagues to reject the politics of the 
past and fight for a better direction for 

our country, for our children, and for 

our grandchildren.

Mr. Speaker, at this point, I am greatly 
honored to yield 3 minutes to the chair-
man of the Ways and Means Com-

mittee, Mr. McCARTHY of California.

Mr. WAXMAN. Mr. Speaker, I ask 

unanimous consent that Members have 

permission to revise and extend his 

remarks.

Mr. KENNEDY. I rise in support of 

the gentleman from Rhode Island for a 

unanimous consent.

Mr. WAXMAN. Mr. Speaker, I urge a 

“no” vote on H.R. 3962 and a “yes” vote 

for the Republican bill.

Mr. WAXMAN. Mr. Speaker, this bill 
reflects the input and the inspiration of 
two Kennedys in the Congress of the 

United States, certainly Senator Ted 

Kennedy, but also Patrick Kennedy, 

who has been such a leader in the areas 
of mental health and addiction.

I yield to the gentleman from Rhode 

Island for a unanimous consent re-

quest.

Mr. KENNEDY. Mr. Speaker, I ask 

unanimous consent that Members have 

5 legislative days in which to revise 

and extend their remarks on H.R. 3962 

and include extraneous material in the 

RECORD.

The SPEAKER pro tempore. Is there 
objection to the request of the gen-
tleman from California?

Mr. RANGEL. We have an expression 

in my community, “God is good,” and 
basically it means that it gives us all 
an opportunity in our lives to do some 
of the things that we had hoped and 
dreamed would be possible. Since God 

has been good to our country and to 

this Congress, it means that we have a 

responsibility to extend our power to 

make certain that people have access to 

health care.

It's really surprising that the other 

side would believe that, as a party, their 

answer to this crisis that we face 
as a Nation in providing health care to 

so many millions of people that don't 

have it, that their answer is “no” and 

their vote will reflect “no.” But a 

short visit to history would see that 

every time we're talking about com-

passion—Social Security, Medicaid, and 

Medicare—their answer is going to 

be “no.”

I want to thank our President for 

recognizing that even though we have 

to carry this load alone, it is an honor 
to be working under the leadership of 

Speaker NANCY PELOSI, our chairmen, 

Chairman WAXMAN and Chairman MI-

LER, and all of the wonderful people 

that have worked together under the 

caucus chair of Mr. Larson, that we all 

think that we only have this one chance to 

get it right; Mr. CLYBURN, who brought 

our votes to-

gather so that we are able to be here on
this Saturday to pass this. But to me, most of all, it would be the hard-working members of my committee, men and women who worked day and night to make certain that we got our initial bill and we also found a way to pay for it. And not only to make certain that the great Nation of ours would not have a deficit but, indeed, would decrease the deficit of this country by $100 billion over 10 years. And the staff, of course, of the Ways and Means Committee serviced not just our committee, but all of the committees in the House and every Member who needed to know just how can we get this thing right and to do the right thing.

How proud we are that nobody is going to be denied health care because they had a preexisting condition before that. How proud we are that we don’t have to select our jobs based on the health insurance that we have. And how proud we are that people who lose their jobs will not be losing their health coverage.

It is a small thing for some people like Members of Congress that already have their insurance, but for those of us that are uninsured it is a struggle to understand what it’s like not to be able to take care of your family or your dear friends, not to be able to have health insurance, and for a Nation to be able to say that we are competing with industrial countries all over the world and they provide education and health care for their children, and this great country of ours, with all of the wealth, have to shamefully say that we can’t afford to take care of our own people.

I urge all of my colleagues to vote for this legislation.

The SKEPER pro tempore. The Chair will note that the gentleman from Texas has 28 minutes remaining, and the gentleman from California has 22 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished ranking member of the Science Committee and a member of the Energy and Commerce Committee, the gentleman from Rockwall, Texas, Congresswoman RALPH HALL.

(Mr. HALL of Texas asked and was given permission to revise and extend his remarks.)

Mr. HALL of Texas. Mr. Speaker. I rise today to urge, of course, a “no” vote on the Democratic health care proposal.

I have five grandchildren, and already they will spend their entire lives paying the debts that we are accumulating in their lifetime before they are even paid. This bill is a generation killer, and the targets are your grandchildren and mine. My Fourth District of Texas is 100–1 against this bill, and I believe it’s a good composite of other districts around the country.

I urge you all to please listen and to vote with your constituents, and I say to Members on both sides of this aisle: remember who sent you here, and vote their wishes. The American people have memories that will survive the actions of today’s vote. They will not forget. I ask you to vote “no.”

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member from California, ANNA ESHOO.

Ms. ESHOO. Mr. Speaker, I come to the floor today to cast one of the most important votes of my congressional career in support of the Affordable Health Care for America Act. This effort is historic, almost a century in the making.

For many of us, this long battle has had a singular, courageous champion who fought like a lion for the sick, the elderly, the left behind, and the left out, Senator Edward Kennedy, and this bill is a fitting memorial to him.

Most uninsured Americans want to purchase health insurance, but they simply can’t afford it. They are priced out. The market priced out, Millions more live under the crushing weight of medical bills that bankrupt households or that shutter small businesses. This bill provides access to affordable health care for every American.

The abhorrent insurance practices of dropping sick patients to avoid paying expensive medical bills and discriminating against those with preexisting conditions will end with this legislation.

Very importantly, seniors, your Medicare will be strengthened; and it will provide you with better care.

I am proud to be part of making history. I think it is a privilege to do so. I urge all of my colleagues to vote for this legislation.

The SPEAKER pro tempore. The Chair will note that the gentleman from Texas has 28 minutes remaining, and the gentleman from California has 22 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the Energy and Commerce Committee, one of our ranking members of the subcommittee, the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. Mr. Speaker. I rise against this bill. I don’t know if you saw the headline today in The Wall Street Journal: “Grim Milestone as Unemployment Tops 10 percent.” Our debt hits revise rate of 10.2 percent with more unemployed. Official figure is highest since 1980. Broader measure stands at 17.5 percent."

Mr. Speaker, I am from Michigan where our unemployment rate exceeds 15 percent. People want to work and pay taxes. They don’t want to be laid off and receive benefits.

This 1,990-page bill is almost 20 pounds. Does anyone actually believe that spending another $1 trillion is going to reduce our unemployment? We add employer mandates. The Joint Committee on Taxation says that one-third of the $460 billion in taxes is going to be paid for by small businesses. How does that decrease our unemployment? It doesn’t.

In closing, Mr. Speaker, let me say this: one of our colleagues today is quoted as saying: Health care costs are rising faster than wages and inflation, and this bill does not change that trend.

That was a Democrat and not a Republican who said it.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member of our committee, the gentleman from New York, ELIOT ENGEL.

Ms. ENGEL. Mr. Speaker, I rise in strong support of the Affordable Health Care for Americans Act.

As a senior New Yorker on the Energy and Commerce Committee and on the Health Subcommittee, I am proud of the role I played in helping to make this bill a reality.

On this historic day, our Congress has a historic chance to serve our citizens; and it honors a moral imperative to provide all Americans with comprehensive, affordable access to quality health care.

This is the reason why so many of us sought public office, and it is the reason by our colleagues to Congress, to right the wrongs of our broken health care system and to steer our country back in the right direction.

No one ever will families worry late into the night over whether their pre-existing medical conditions will prevent their loved ones from getting access to the health care coverage they so desperately need. Never again will insurance companies be allowed to drop coverage for those who have paid their premiums diligently only to have their policies canceled when they get sick and need it the most. Never again will families have to worry that, if they lose their jobs, they will also lose their health care coverage.

Don’t believe the scare tactics you are hearing from the other side. This bill is good for seniors, good for young adults, and good for all Americans. I urge my colleagues to support the bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished former mayor of Fort Worth, Texas, the Honorable KAY GRANGER.

Ms. GRANGER. Mr. Speaker, unemployment is over 10 percent in this Nation and the budget deficit is $12 trillion. Our deficit is $1.4 trillion.

Families are sitting at their kitchen tables trying to figure out how to pay their bills. Businesses have cut everything they can cut just to keep their doors open. Grandparents are taking in their grandchildren in their old age.

We are going to vote another $1 trillion so government can take over our health care, cost those families more money, throw more mandates on our States, add 118 new departments and agencies to this already bloated Federal Government, take Medicare Advantage away from our seniors, let the health choices commissioner take
place of our family doctors, mandate health insurance with jail for not complying with or for paying a tax, and ignore the voices of thousands of people who came here and who said, Listen to us. Don’t pass this bill.

Mr. Speaker, what are people in this Chamber thinking of?

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member of our committee, the gentleman from Texas, GENE GREEN.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. This is a momentous day like that day in 1935 when Social Security was created and also like that day in 1965 when Medicare was passed.

We are in desperate need of health care reform. Health insurance premiums are growing three times as fast as wages; and, last year, more than half of Americans postponed medical care or skipped their medications because they couldn’t afford them.

The 29th District in Texas, which I represent, has the highest number of uninsured individuals in the county as 40 percent of the residents are uninsured. If enacted, H.R. 3962 will provide coverage to 96 percent of all Americans and to 230,000 currently uninsured residents in our district. It will also improve the employer-based coverage for 277,000 employees in our district.

H.R. 3962 will give individuals the ability to access quality, affordable health insurance. They will no longer be denied coverage for preexisting conditions, and their coverage will not be capped or dropped when they are sick. The bill ensures no more out-of-pocket expenses for what insurance companies will cover, and it provides premium subsidies for those who need it.

This is not government controlled medicine—individuals will be able to choose their own insurance plan and their physician.

This bill ensures individuals will be able to have access to primary and preventive care services. It will make it possible for a doctor before they are sick, and be able to access quality medical services.

H.R. 3962 will rein in rising health costs for American families and small businesses—introducing competition that will drive premiums down, capping out-of-pocket spending.

The time for health reform has come and I urge my colleagues to vote in favor of H.R. 3962 not only for my constituents, but for all Americans.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to one of the distinguished ranking members on the Energy and Commerce Committee, the gentleman from Florida (Mr. CLIFF STEARNS).

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

Mr. STEARNS. I thank my colleague. Mr. Speaker, I rise against this bill. The Congressional Budget Office has said that this bill will remove $54 billion. Instead, we get a bill today that makes a mockery of health reform.

The Democrats add a provision that will clearly increase costs for health care and that will make it harder to recruit doctors. The new language explicitly prevents States that accept these grant funds from capping noneconomic damages or attorneys’ fees even if it is currently unconstitutional.

 Said another way, the Secretary of Health and Human Services can give such sums as he deems necessary to any States that do not cap attorneys’ fees, or, sadly, the bill undoes all States’ tort reform.

This bill violates States’ rights. It undermines their efforts at real tort reform. It allows trial lawyers to begin on season on our doctors and medical providers.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a very active and important member of the Health Subcommittee and of the full Energy and Commerce Committee, my colleague from California, LOIS CAPP.

Mrs. CAPPS. Mr. Speaker, I am honored to endorse this historic legislation today which improves health care for all Americans and focuses on the benefits for women’s health.

When this bill becomes law, a woman will no longer be discriminated against by an insurance company simply for being a woman. Women will no longer be discriminated against by insurance companies for being victims of domestic violence. Women will automatically be covered for maternity care. Women will not have to pay co-pays for important preventative screenings like mammograms and cervical cancer.

Most importantly, women who make the bulk of the health care decisions for their families will have access to quality, affordable health care for their families.

This is an excellent bill, and I am humbled by the fact that, as a Representative of the 3rd Congressional District in California—a nurse, a mother and a grandmother—I am privileged to vote today in favor of this bill. I urge all of my colleagues to do the same.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to another of my distinguished ranking members on the Energy and Commerce Committee, the gentleman from the Bluegrass State of Kentucky (Mr. WHITFIELD).

Mr. WHITFIELD. Mr. Speaker, there are many provisions of this 2,000-page Affordable Health Care for America Act that we can support on this side.

Yet we do not support the establishment of a Federal health care board to control health care in America. We do not support establishing civil penalties of up to $10,000 a day for violating health regulations. We do not support reducing Medicare funding by $500 billion. We do not support cutting funding for hospitals by $155 billion and rural hospitals by $6 billion between 2017 and 2019. We do not support increasing taxes on small business owners, particularly at a time when we have an unemployment rate of 10.2 percent.

If we had a surplus, we could support spending billions of dollars for the sovereign states of Micronesia, the Marshall Islands and Palau. Since we have a $11 trillion debt, why should we be spending money for health care in those countries? We are also increasing the bill by billions with new benefits to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. DOYLE).
We could be here today talking about real reforms, medical liability reform, access for everybody regardless of pre-existing conditions. We think you can do that by expanding a risk pool concept. It costs a little money, but it doesn’t cost billions and billions and billions of dollars. If we could find Medicare savings.

Mr. Speaker, we should use those Medicare savings to save Medicare. Only the government would have made a commitment to a program like Medicare, because it is in huge trouble beginning in about 2017, and here today saying we should make savings from that program to fund a new program. If there are savings in Medicare, we should use them to save Medicare, Mr. Speaker.

I hope we reject this bill. Even if this bill passes today and doesn’t go further than this, I hope we can work together to do the things we really need to do to reform the system.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentleman from the State of North Carolina, an important member of our committee, Mr. BUTTERFIELD.

Mr. BUTTERFIELD. I thank the gentleman for the time.

Mr. Speaker, later today we will have an opportunity to fix a broken health care system. I have listened to both sides of this debate, I have read everything available, and I have prayed for guidance.

We have an obligation, constitutional and moral, to provide for the general welfare of every American citizen. Allowing a broken health care system to continue to bankrupt families, businesses and hospitals and deny coverage to millions is a failure of duty.

We must act now. Reject the false rhetoric surrounding this debate. Reject the false claims about Medicare coverage reductions. The bill strengthens the idea that the false rhetoric about government-run health care. The bill provides healthy and needed competition.

Reject the claim that this legislation will increase the debt. Doing nothing will increase the debt by billions. We should not delay any longer.

I urge my colleagues to vote “yes” on this legislation.

Mr. BARTON of Texas. Mr. Speaker, I see that we have changed from the Jets and the Giants to the Green Bay Packers in the chair.

I would like to yield 1 minute to a Ramblin’ Wreck from Georgia Tech, a member of the Committee on Energy and Commerce, Dr. GINGREY.

Mr. GINGREY of Georgia. Mr. Speaker, having spent most of my life in medicine and healing the sick, I rise in strong opposition to this bill. With double-digit unemployment at 10.2 percent, this so-called reform, which will destroy an additional 5.5 million jobs, is not what the American people want. Yet their opposition and protests have fallen on deaf ears as this majority simply does not seem to care.
taxpayers and patients alike. Americans pay the highest prices for prescription drugs in the world and this bill binds us to that fate.

For every Member of Congress, there are two and a half pharmaceutical lobbyists. In the first half of 2009, drug companies spent $609,000 every day on lobbying. We have missed an opportunity to tell the drug companies that they no longer set the agenda in Congress.

We have missed an opportunity to put the interests of Americans ahead of special interests. We have missed an opportunity to end the pill-splitting, skipped doses and unfilled prescriptions that plague Americans who can’t afford the medicine their doctor prescribes.

This bill shifts those costs from patients to taxpayers, from this generation to the next. It trades affordable generics for pricey name-brand name drugs. It intentionally makes quality care unaffordable for our Nation, and it is wrong to leave hundreds of billions in savings on the table.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to a very important member of our committee, the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Speaker, as a family physician who practiced for more than 20 years, a mother, a grandmother and an American, I am proud to stand here in support of the Affordable Health Care for America Act. This bill is for the many patients I know who put off health care until it was too late because they couldn’t afford it and the tens of millions like them who will now have access to full health care.

This year and every year past, over 80,000 African Americans died, whose deaths were preventable, because they were unable to get health care. This bill is for all people of color, those in our rural areas, the territories and the poor, because beyond insurance, this bill will provide the services some of them never had.

H.R. 3962 will give young people for whom a health care professional is out of the reach the opportunity to help heal their communities. It will cover 36 million uninsured people, making insurance secure and affordable, strengthen prevention and public health, improve Medicare and Medicaid, help poor communities, create an environment that supports good health, and finally begin to eliminate health disparities.

Today we have the opportunity to vote for health and a better life for everyone in this country and for a better country where life, liberty and the pursuit of happiness is truly a right for all.

Let’s make history together. Vote “yes” for affordable health care for America.

Mr. BARTON of Texas. Mr. Speaker, I recognize one of my ranking subcommittee members, Mr. RADANOVICH, who represents Fresno, California, for 1 minute.

Mr. RADANOVICH. Mr. Speaker, we are standing on the precipice of a major shift in this country’s history. In less than a year, this President’s administration, with the Pelosi Congress, has recklessly spent taxpayer funds to expand government to a level never before seen in history.

The government is now more involved in our lives than I think any of us could have imagined. The result has been double-digit unemployment for the first time since the early 1980s. And now we are going to vote on whether the government should take over the Nation’s health care system at a cost of $1.3 trillion and up to 5.5 million jobs.

Despite all this, the leadership of this Congress has chosen to ignore the will of the people and say, America, you are wrong. We know what’s best for you. Well, this is not what the American people want, and it certainly is not what the doctor ordered for health care improvement.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY), a senior member of the Energy and Commerce Committee.

Ms. SCHAKOWSKY. This is a great moment in history because today we act to guarantee affordable health care for this and future generations. It is a great day for women. Our bill stops gender rating, preventing insurance companies from charging women 48 percent more than men for the same coverage.

We eliminate preexisting conditions. Being a breast cancer survivor or domestic violence victim will no longer prevent access to care. We require coverage of maternity and well-baby care. We ensure that older women not yet eligible for Medicare can buy affordable coverage.

We improve Medicare. Senior women will be able to afford preventive services like cancer screenings because we eliminate cost-sharing. We close the doughnut hole, so they can afford their medications.

Women need health care reform. They need H.R. 3962.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the honorable gentlewoman from North Carolina (Mrs. MYRICK), a cancer survivor.

Mrs. MYRICK. Mr. Speaker, Americans are struggling with health care costs. We all know that. Too many families can’t afford coverage, and small businesses are struggling to find coverage for their employees.

However, this bill does not fix the underlying problem, the cost of health insurance. It is an unprecedented expansion of Federal Government spending that will only dig a deeper hole of debt for generations to come.

Margaret Thatcher once said, “We want a society in which we are free to make choices, to make mistakes, to be generous and compassionate. Not a society in which the State is responsible for everything, and no one is responsible for the State.”

The majority’s bill creates a society that resembles the latter, and it is a mistake. I urge my colleagues to vote “no.”

Ms. BALDWIN. Mr. Speaker, can I inquire how much time is available on each side?

The SPEAKER pro tempore. The gentleman from California has 13 1⁄2 minutes remaining. The gentleman from Texas has 17 1⁄2 minutes remaining.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Speaker, I rise in support of this bill, which will provide affordable health coverage to 36 million people who lack it today. This has been an aspiration for our Nation and our people for decades.

I ran for office motivated by my belief that every American should have access to quality health care, and I will not stop fighting until every American is covered. There are far too many daily reminders of the failures and injustices of our current system, the countless stories of bankruptcy, care delayed and premature death. And yet we have let years go by while people suffer.

Today, we convene to debate and advance legislation that delivers meaningful insurance reform, outlawing outrageous insurance abuses, lowering costs, and extending coverage to all. I will cast my vote today on behalf of the people in Wisconsin and millions throughout America who have said enough is enough.

Today, we declare with conviction: every American deserves health care, and every American shall have it.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the sixth Frelinghuysen to represent a district from the Garden State of New Jersey, the Honorable ROYDEEN FRELINGHUYSEN.

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

Mr. FRELINGHUYSEN. Mr. Speaker, I yield the gentleman for yielding.

Mr. Speaker, I rise in opposition to this legislation because I have been listening to my constituents. Over the past several months, I have received over 13,000 letters, emails, faxes and calls from New Jersey families and employers. Unprecedented. I have listened to hundreds of residents in town hall meetings, retirement communities, nursing homes and senior clubs.

I have visited areas hospitals and businesses, large and small. I have met with medical societies, health providers, doctors, nurses, anesthesiologists, home health aides, chiropractors, surgeons, all of them.
In each of these meetings, these men and women have expressed deep concern about the so-called health care reform that has been sponsored by the House majority, the Pelosi bill, and most are opposed. They are worried about what they call this "health care takeover." The House majority has heard their concerns. They have worked with the Small Business Administration on this sort of outreach and education.

Mr. WAXMAN. Yes. The bill ensures the commissioner will work with the Small Business Administration. Mr. FRANK of Massachusetts. I thank the gentleman. I assume he has heard that work will go on. I have been asked to work with the Small Business Administration on this sort of outreach and education.

Mr. WAXMAN. Mr. Speaker, I am proud to yield 1 minute to the gentleman from Pennsylvania (Mr. Prrrs), one of the strong pro-life leaders in the U.S. Congress, a combat veteran of Vietnam, and a member of the Energy and Commerce Committee.

Mr. PITTS. Mr. Speaker, there has been some recent confusion surrounding the inclusion of abortion coverage in H.R. 3962, but the issue is actually quite clear. The Capps amendment in the bill, which some have argued is neutral on abortion, explicitly authorizes the Federal Government to directly fund elective abortions using Federal funds drawn from a Federal Treasury account. The provision has been billed as a so-called compromise amendment. But this bill will radically expand current and longstanding Federal policy with respect to abortion.

Currently, there is not a single government health care program that provides coverage for elective abortion; not SCHIP, not Medicaid, not DOD, Indian Health or the Federal Employee Health Benefit Program, all because of congressional action to explicitly prohibit coverage of abortion under each of these programs. But such an explicit exclusion is missing from this bill. Therefore, I urge my colleagues to support, when it comes up later, the Stupak-Pitts-Smith-Elwsworth-Dahlkemper-Kaptur amendment that would prevent Federal funding of abortion in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Ms. CASTOR), a member of our committee.

Ms. CASTOR of Florida. Mr. Speaker, Democrats will now deliver on what American families and businesses have been asking for when it comes to their health: one, meaningful, secure and stable insurance; two, improved Medicare for seniors; and, three, vital consumer protections.

For families with health insurance, health reform will provide you with coverage you can count on. Families will no longer have to worry about insurance companies canceling their coverage because someone in their family gets sick. Health insurance companies will no longer be able to bar you from insurance just because you have diabetes or cancer or some other chronic condition.

American families have been doing everything right. They have been paying their copays and paying their premiums, even as those costs have risen dramatically. Our health bill says that in return, that coverage must be meaningful, stable and secure. And for our family members who rely on Medicare, you will see immediate improvements, in your prescriptions, your checkups, and a provision I worked on, to penalize unscrupulous practices of private Medicare insurance sales agents.

The meaningful health reform that will pass the House today builds on the great legacies of Social Security and Medicare, and I am proud to represent from left to right, on behalf of the people of Wyoming, where individual freedom and personal responsibility are hallmark values.

This $1 trillion tax-everybody-right-down-the-wheelchair, debacle will impact every person in Wyoming. This bill will force my constituents to buy insurance, whether it makes sense for them or not. This bill will dump some of my constituents into a government-run health care program to which Members of Congress will not even be subject themselves.

I sought an amendment that would allow States to shield their citizens from government-forced insurance, from higher taxes, and practical mandates on business and on individual freedom and personal responsibility. It was not successful.

Our Constitution was designed to empower the American people and shackle the Federal Government. This bill will shackle the American people while empowering the Federal Government. It is a sad day for Wyoming, Mr. Speaker.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. PATRICK J. MURPHY), who has been a leader in our efforts to lower growth in premiums through measures such as immediate review and justification of insurance rate increases.

Mr. PATRICK J. MURPHY of Pennsylvania. Colleagues, voting "yes"
force the States and the localities to Medicare and Medicaid and imposes crushing taxes on small business of health care decision-making, tem. overhauls the present health care system to become uninsured. But instead of skyrocketing health care costs do legends. Omaha, Nebraska, the home of the College World Series. Mr. Speaker, as I said, I am a proud Blue Dog Democrat, and there is universal agreement that to get our country’s fiscal house back in order, we must first get our health care spending under control. And this bill does just that. It actually reduces our deficit by $129 billion, taking important steps to rein in health care costs. But there is more work to be done, and I look forward to working with you and our leadership to accomplish this goal.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WAXMAN. Mr. Speaker, I yield the gentleman an additional 10 seconds. If the gentleman would permit, I want to thank you for your leadership, and assure you we are going to continue to work in conference to do everything we can to make coverage affordable for the American people.

Mr. TERRY. Mr. Speaker, it is clear that skyrocketing health care costs do exist, causing a number of Americans to become uninsured. But instead of addressing these issues, the Speaker has offered us a bill that dramatically overhauls the present health care system. It injects government into every corner of health care decision-making, from arming the Health Choices Commissioner with unprecedented power to dictate coverage and influence costs, to imposing crushing taxes on small businesses. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business.

We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in entitlement obligations. I am also deeply concerned about the national debt, which has doubled since 2000 and is nearing $12 trillion for the first time in our history. Any plan put forward must control costs, not add billions of dollars to an already ballooning deficit.

America is going broke. Is this the legacy this Congress wants to leave our children and grandchildren?

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Connecticut (Mr. MURPHY).

Mr. MURPHY of Connecticut. Mr. Speaker, every night in my State, thousands of kids go to sleep sick in their beds just because their mothers can’t afford to take them to doctors. This is the most affluent, most compassionate Nation in the world, and it makes absolutely no sense that our health care system is the most inefficient, most unfair in the world. But to change this, we don’t need to throw out what we’ve got, but to make it work.

Despite all this nonsense political speak from the Republicans about government takeovers, this bill simply seeks to reset the rules of the private health care marketplace so that it stars working again like it should, so that small businesses can band together to negotiate for lower prices, so that individuals will have access to tax credits to help them pay for private insurance, insurance that’s fair and doesn’t discriminate against them because they’re sick. We’ll fix this crisis in our health care system all on the shoulders of a reformed private system so that never again does a child fall asleep sick in his bed because his country, the most powerful in the world, didn’t have the coverage to make him well.

Mr. BARTON of Texas. I would like to recognize the gentleman from Virginia, Congressman FRANK WOLF, for a unanimous consent request. (Mr. WOLF asked and was given permission to revise and extend his remarks.)

Mr. WOLF. I rise in strong opposition to the bill because our Nation is going broke. I rise in opposition to this bill.

We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in entitlement obligations. I am also deeply concerned about the national debt, which has doubled since 2000 and is nearing $12 trillion for the first time in our history. Any plan put forward must control costs, not add billions of dollars to an already ballooning deficit.

America is going broke. Is this the legacy this Congress wants to leave our children and grandchildren?

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Connecticut (Mr. MURPHY).

Mr. MURPHY. Mr. Speaker, I yield the gentleman an additional 10 seconds. If the gentleman would permit, I want to thank you for your leadership, and assure you we are going to continue to work in conference to do everything we can to make coverage affordable for the American people.

Mr. TERRY. Mr. Speaker, it is clear that skyrocketing health care costs do exist, causing a number of Americans to become uninsured. But instead of addressing these issues, the Speaker has offered us a bill that dramatically overhauls the present health care system. It injects government into every corner of health care decision-making, from arming the Health Choices Commissioner with unprecedented power to dictate coverage and influence costs, to imposing crushing taxes on small businesses. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes on small business.
deficit; how to ensure that U.S. taxpayers are not subsidizing health insurance for those illegally in our country; how to ensure that the self-employed and small business owners receive adequate insurance, and how to ensure that young adults can continue to be carried under their parents' health plan until they reach age 25.

There are concerns about a government-run insurance option and what that will mean in the way of costly mandates for small businesses and employers during a time when unemployment is teetering near 10 percent. I am also concerned about how Americans will pay for a $900 billion plan as our country seeks to work its way out of an economic recession and faces trillions of dollars in debt and a growing annual deficit that could be near $2 trillion. I also have questions about half trillion dollars in savings in Medicare and Medicaid costs. What will that mean for senior citizens today?

"We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in promised entitlement obligations through Medicare and Social Security. I am also concerned about the national debt, which has doubled since 2000 at a cost of $2 trillion for the past two years in our history, and unprecedented federal deficits, which could result in increased interest rates for consumers if we continue to finance government by borrowing from foreign lenders. I have the leading bill in the House to establish a bipartisan commission to review entitlement spending with tax policy or any other tools to ensure that Congress addresses these spending issues, which if left unchecked, will be disastrous for future generations. (For more information about the SAPF, please go to www.help frankly.)"

"I again want to emphasize: it is important for Congress to fix what's broken with our nation's health insurance system. But we have to do it the right way without changing what is working. We need a plan that controls costs without adding billions of dollars to an already ballooning deficit; ensures competition and choice; provides that patients and their doctors make the decisions on medical care rather than a government-run agency skimming medical liability costs and tort reform."

"I believe that the legislation in the House fails all of these tests, and that Congress has a lot more work to do to provide the kind of health reforms Americans want and need."

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the former FBI man from Colorado, Mr. ROGERS, a member of the committee.

Mr. ROGERS of Michigan. Mr. Speaker, there are huge consequences to the 85 percent of Americans who have employer-based coverage. This bill. Not only will they get longer wait times and more expensive premiums, but at the end of that, with new debts, some $1.5 trillion in new spending, 18 million Americans won't have coverage. But more importantly, there will be less medical care for them.

There is nothing more sacred than the bond between a mother and a child, that trust, that love, that nurturing when that child is sick. And when a mother goes to see the doctor under that 2,000-page bill, her relationship can be jeopardized, they don't get to see her patient and their doctor, and what that mother wants for that child is no longer sac-

cred, because now, through the 118 different boards and commissions, their comparative effectiveness research allows the Federal Government, through a forced government insurance, to ration and deny care. You have violated the most important trust, the most important thing that have in building the block and the foundation of the values of this country. That mother, that doctor knows what's best for that child. You will find no compassion in a Federal bureaucracy.

Mr. ROGERS. I would urge the strong rejection and the protection of that bond between doctor and patient and mother and child.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Colorado, Mr. SALAZAR.

Mr. SALAZAR. Mr. Speaker, I am especially pleased that this bill will help rural America. Currently, physicians in rural areas are reimbursed less from Medicare than their urban counterparts. If the legislation passes, care physicians in rural areas 10 percent more than the urban physicians not only to equalize the disparity, but to make rural communities more attractive to physicians.

Today we act to improve the health insurance situation in all my counties, to increase the number of physicians in my counties, to improve access for 106,000 Medicare beneficiaries.

This bill will expand insurance coverage to 111,000 currently uninsured residents in my district. In my district, it will protect 900 families from going bankrupt due to excessive health care costs. It will help 148,000 low-income families pay for their insurance.

Our current system is broken, and it is time to fix it now.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from the Pelican State, Congressman SCALISE from New Orleans, a member of the committee.

Mr. SCALISE. I want to thank the ranking member from Texas for yielding.

I rise in opposition to Speaker PELOSI's 1,900-page government takeover of health care. Weighing in at nearly 20 pounds, this bill comes out to over $7,000 per page. And where does this bill spend that money? Well, first of all, it falls the American people. It falls those small businesses and families that are going to have to pay the $730 billion in new taxes in this bill. It falls our seniors who have to deal with over $500 billion in cuts in Medicare. And it falls many of President Obama's own pledges and promises he made right here on this floor, like when he said, if you make less than $250,000 a year, you won't pay any new taxes.

In this bill, there is over $20 billion of new taxes just on people who have no insurance. The President has said multiple times, If you like what you have, you can keep it. Unfortunately, this bill fails the President's promise because it allows the health care czar to take away your insurance even if you like it. It's so bad, that even when we brought our amendment to say all you have to do is change the word Medicare in this bill, they actually refused to allow a vote on that amendment.

We need to defeat this legislation and do real reform.

The SPEAKER pro tempore. The Chair would announce that the gentleman from Texas has 11 minutes remaining, and the gentleman from California has 6½ minutes.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Ohio, Betty SUTTON, a member of our committee.

Ms. SUTTON. Mr. Speaker, the American people have been waiting for this day, a day that we will finally pass a health care bill that will work for America and that they can believe in with access to more affordable quality care, care that they can count on.

Mr. Speaker, they have been waiting for us to put an end to the egregious discriminatory practices of insurance companies who deny them coverage based on preexisting conditions and place caps on coverage to prevent people from accessing the care they need just when they need it the most.

Today we act to improve the employer-based coverage for 420,000 residents in my district, to improve Medicare for 107,000 beneficiaries, and to move to close the prescription drug doughnut hole for seniors across this country.

Yes, Mr. Speaker, the American people have been waiting, and today we act for a health care system that will work for and with them.

Mr. BARTON of Texas. Mr. Speaker, could I ask how much time? You said a minute ago, but I was not listening.

The SPEAKER pro tempore. The gentleman from Texas has 11 minutes remaining. The gentleman from California has 5½ minutes remaining.

Mr. BARTON of Texas. Thank you, Mr. Speaker. I was listening to my distinguished friends on the majority rapty.

I now yield 1 minute to one of our doctors, physicians, the gentleman from Lewisville, Texas, the Honorable Mover-based Business, also a member of the committee.

Mr. BURGESS. I thank the gentleman for yielding.

Last spring and summer, as we got into this debate, America's doctors were pretty clear of what they wanted to see if Congress was going to undertake health care reform. They wanted to see some relief in the medical justice system. They wanted to see some medical liability reform. They desperately needed a fix to the payment and Medicare Medi-gap. They need reductions in Medicare reimbursement rates every year for as far as the eye could see, and they wanted a little help with
antitrust relief. After all, if we’re going to ask our doctors to be our partners in this brave new world of health care reform, the least we could do is let them talk amongst themselves about the best way to deliver high-quality care at low cost.

Well, what happened? Antitrust; not in this bill. SGR; we’ll take that up at some point in the future. Medical liability; a smidgeon of medical liability reform in this bill, but nothing compared to what doctors actually need.

In Texas, the State has done what this country needs to realize would be the way forward in medical liability reform. Caps on noneconomic damages have worked in the State of Texas. You don’t have to take my word for it. There are almost 15,000 new physicians that have come to the State of Texas since 2003 when this was enacted. There are 82 counties that now have doctors which did not have them before. Emergency room services and OB service particularly have seen significant increases since Texas passed their sensible liability reform.

Mr. WAXMAN. Mr. Speaker, for a unanimous consent request, I yield to the gentleman from Iowa (Mr. BOSWELL).

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

Mr. BOSWELL. I rise in support of this bill. The people in my area are waiting and so is my State and our country.

Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act.

Today, I am pleased to vote for the transformative piece of legislation that I have considered during my 13 years in Congress. I am voting to grant access to health care coverage for 18,000 uninsured constituents in my district and to make it more affordable for another 440,000 insured.

I am voting to require that 6,400 of my constituents with preexisting conditions could never be denied coverage and to reduce insurance costs for 14,800 small businesses.

I am voting to finally address how Iowa’s hospitals and providers have shouldered the burden of unfair Medicare reimbursements for the high-quality care they provide for too long. This bill will require studies on the reimbursement formula and move toward a payment system based on quality, not quantity. Providers who participate in the public option would be reimbursed through negotiated rates that balance what private insurance companies pay for services with the current Medicare rates.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. PERRIELLO) for the purpose of a clarifying statement.

Mr. PERRIELLO. Chairman, I recognize the good things this bill does to make health care more affordable for families and expand access to preventive care and I just want to clarify for the record that maternity care is a required benefit in the essential benefits package for all individual insurance and employer insurance across the country.

Mr. WAXMAN. If the gentleman will yield, yes, it is. That is a correct statement.

Mr. PERRIELLO. And it is my understanding that prenatal and postnatal care is generally considered to be part of maternity care, as recognized by organizations such as the American College of Obstetricians and Gynecologists.

Mr. WAXMAN. The gentleman is correct in that statement. Mr. PERRIELLO. Thank you, Mr. Chairman, for this clarification.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Phoenix, Arizona, Congressman Joni STADHEgger, a member of the committee.

Mr. SHADEGG. I thank the gentleman for yielding.

This is Maddie. Maddie believes in freedom. Maddie likes America because we have freedom here, and Maddie believes in patient-choice health care. She asked to come here today to say that she doesn’t want the government to take away her health care. She wants to be able to keep her plan.

You see, Maddie knows that if this bill passes, it says that her mom’s health care goes away and won’t be around in 5 years. As a matter of fact, the bill says, if the bill passes, then no more health care for her mom because it has to change.

Maddie wants patient choice. Maddie doesn’t want her mom’s premiums to go up. She doesn’t want her mom’s taxes to go up by $730 billion. Do you, Maddie? That’s too much money.

Maddie doesn’t want a health care bill that will cost $1.5 trillion. She wants America’s health insurance companies to have to compete with each other.

She believes in choice, but most of all, Maddie says, Don’t tax me to pay for health care. I’ve got no money. If you want health care, pay for it yourself, because it’s not fair to pass your health care bills on to me and my grandchildren.

Thank you, Maddie.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The gentleman is reminded not to refer to guests of the House as props.

Mr. WAXMAN. Mr. Speaker, that was a remarkable child and a great ventriloquist. I would like to yield for a unanimous consent request to the gentleman from Virginia (Mr. BOUCHER).
The district I represent closed for periods of time in recent years for financial reasons. The government owned insurance plan as outlined in the House bill could push many more over the edge. I cannot support legislation that could lead to that result.

I also believe that bipartisan participation is needed on a measure of this scope which affects every American. The best ideas of Democrats and Republicans alike should be drawn upon to fashion the final legislation. That did not happen as the House bill was constructed.

In July, I opposed the health care reform measure as it was considered by the House Energy and Commerce Committee and expressed my concerns at that time. The bill passed by the House did not address those concerns.

Passage of the House bill is but a first step in a long legislative process to final enactment of a reform. I look forward to future steps in that process offering an opportunity for my concerns to be resolved.

Reform is needed, and I hope to support the final passage of legislation that emerges from a House-Senate conference that creates affordable access to health care for all Americans and does so in a way that enables the continued delivery of the excellent care now offered in our region.

Mr. WAXMAN. At this time, I yield 1 minute to the gentleman from the State of Maryland (Mr. SARBANES), a member of our committee.

Mr. SARBANES. Mr. Speaker, every day millions of people wake up with a knot in their stomach because they have anxiety and fear that they may lose their health care coverage or they don’t have it to begin with. They need this health care bill. We in this Chamber are conscious of the sweep of history, but the people in my district and millions more across the country have a much less ambitious perspective. They just want to know is this a good bill, does it make sense, and will it help them and their families.

Well, if you are a senior, the answer is yes. To begin closing the doughnut hole. If you are a young person, the answer is yes. You can now stay on your parents’ policy through age 26. If you are a working adult, the answer is yes, because we’re going to curb the abusive practices of the health insurance industry.

So what I want to say to people in my district and to others is this is a good bill, it makes sense, and it will help millions of Americans across this country.

I yield its passage.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the gentleman from the Hoosier State of Indiana, Mr. STEVE BUYER, another member of the Energy and Commerce Committee, and the ranking member on the Veterans’ Affairs Committee.

Mr. BUYER. Mr. Speaker, in a few days, all of us are going to be going back to our districts. We are going to be celebrating Veterans Day. Many of you are going to be giving speeches.

You are going to be throwing your arms around the soldier, the marine, the sailor, the airman, the coast-guardman. Do you throw your arm around them in this bill? You don’t.

And when you go home and you give that speech, you can tap into the American character, and you can say, Americans go to a land where they’ve never been to fight for a people that they’ve never met. They do so at no bounty of their own, and they leave freedom in their footsteps. Yet when they get to come home, how does our Congress right now treat them? In this 2,000-page bill, we deny them their rights of choice with regard to the health system which they can go to. Can you imagine that?

Now, I received a pledge not only from the Speaker, but also from the leadership, that veterans would be taken care of in this bill. My amendments were denied last night in the Rules Committee. How do you deny veterans their choice in this bill?

Shame on this institution.

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

Before I yield to another very important member of our committee, I just want to set the record straight. We keep faith with the veterans in this bill. We allow them to keep their veterans benefits. We allow them to keep their benefits. They may, if they choose to, go into the exchange; but if they don’t, they keep their benefits.

Mr. BUYER. Will the gentleman yield?

Mr. WAXMAN. I yield 1 minute to the gentleman from Iowa (Mr. BRALEY), a member of the Energy and Commerce Committee.

Mr. BUYER. We do not. Mr. Speaker, we don’t protect veterans’ rights.

The SPEAKER pro tempore. The gentleman from Iowa (Mr. BRALEY) is recognized for 5 minutes.

Mr. BRALEY of Iowa. I thank the gentleman for yielding. I do not know whether the gentleman from Indiana will yield or not.

The SPEAKER pro tempore. The gentleman from Iowa (Mr. BRALEY) is recognized for 5 minutes.

Mr. BRALEY of Iowa. I thank the chairman for his extraordinary leadership on this bill.

Mr. BUYER. Mr. Speaker, I rise today on the third anniversary of my election to Congress to urge my colleagues to speak truth to fear and vote for the Affordable Choices for America Health Care Act.

We were elected, my class, to come and change the direction of this country. That’s exactly what this bill does.

We just saw a beautiful young child. I want to tell you about another beautiful young child, Tucker Wright, my nephew’s son, who at age 18 months was diagnosed with liver cancer. Had he two-thirds of his liver removed, and faces a lifetime of expensive medical care. Tucker was lucky because both of his parents work full time. Both of them have health care. And yet he still has tens of thousands of uninsured medical costs that his parents have to pay for.

That is what’s wrong with health care delivery in this country. That’s why we need to reform health care. And that’s why this bill will do for America what we should have done 100 years ago: provide health care for all Americans as a matter of right, not as a matter of privilege. And that’s why I support this bill.

Mr. BACHUS. Mr. Speaker, when I joined the Army, they sent me to Fort Lewis, Washington; and one of the first things we did there was get in line to get our hair cut.

We noticed on the wall there were pictures of four different haircuts, and they told us to choose one of those haircuts, get a number, and give it to the barber.

We thought this was going to be pretty good. So we all gave him that number for the longest haircut. We all gave our numbers to the barber, and he cut all our hair off, every one of us. The numbers meant absolutely nothing.

When we got back to the barracks, we knew who was in charge. We knew who was making the decisions, and it wasn’t us. The Army was making all the decisions.

Just like thinking you’re going to get the haircut you choose, we’re promised the right to choose under this bill. But the reality is, just like the Army, when the government’s in
charge, you're not. This bill is about a new government bureaucracy making all the choices for us. We're Americans. America is about freedom. Freedom is about making choices. And given the choice, I'll always put my faith in the individual, not the government.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from the State of California (Mrs. Davis) for the purposes of a colloquy.

Mrs. DAVIS of California. Mr. Speaker, I appreciate the opportunity to raise this issue also on behalf of my colleague from California, Congresswoman HARKIN.

Unfortunately, the provisions in section 309 allowing States to enter health insurance compacts may bring unintended consequences that could threaten long-established patient protections, and I know that that is not the intention.

I certainly plan on supporting this legislation today; but I would ask you for the commitment, Mr. Chairman, to continue working on the language in section 309 to ensure it does not impact strong State consumer safeguards such as we have in California.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from California.

Mrs. DAVIS of California. Mr. Speaker, I yield to my friend from Nebraska, Congressman FORTENBERRY of Lincoln, who is the largest city in Nebraska.

Mr. FORTENBERRY. I thank the gentleman for the opportunity to raise this issue also on behalf of my colleague from California, Congresswoman HARKIN.

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Lubbock, Texas, a recent beneficiary of the best health care system in the world, Congressman RANDY NEUGEBAUER.

Mr. NEUGEBAUER. Mr. Speaker, I rise today as a proud cancer survivor.

August 1 of this year, I was diagnosed with the early stages of prostate cancer. Not once did thank goodness I live in America and I was able to sit down with my doctor and work out a treatment plan that would help me be cancer free and stand before you today. Thank goodness that I live in a country where I could go and see my doctor and make choices. And thank goodness I live in America where I didn't have to get on a list to determine when I was going to be able to have the surgery so that I could get rid of this cancer. Thank goodness I'm not living in Canada where they're still working on that. Our colleagues on the other side of the aisle are trying to model America's health care system on.

I thought about during August a young lady named Candy Menville that was crying in her wheelchair and begging me to make sure that we didn't turn our health care system in America into the same system that's in Canada and Europe. She said, Congressman, with tears running down her eyes, don't take away my options. Mr. Speaker, don't take away Cindy's option and don't take away my options and others like me. Vote down this terrible bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. COLE. I thank the gentleman for yielding.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. CUMMINGS).

Mr. CUMMINGS. Mr. Speaker, this afternoon we've heard a lot of people saying we should do what our constituents want that we should do.

I ask them what do I say to the gentleman in my district who is suffering from cancer and who is now trying to choose between eating and paying a high copayment for chemotherapy?

What am I to say to the young writer who for years paid her premiums and then, when she got pregnant and had her baby, they gave her a present on the way out the door that she could not afford: a $22,000 bill?

What do I say to lady who suffered from breast cancer in my district and when she lost her job, lost her insurance, could not get insurance, could not get it because of something called preexisting conditions?

I would say to all those folks who are saying that we do not need this and must not do this, we have a moral authority to our fellow citizens. A moral authority.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to one of our pro-life leaders, the Honorable CHRIS SMITH of New Jersey.

Mr. SMITH of New Jersey. Mr. Speaker, today the House has an opportunity to significantly limit public funding of abortion in a manner that replicates the Stupak-Pitts amendment and applies it to the two new massive government health care programs created in the pending bill: the public option and affordability credit program.

The Stupak-Pitts amendment ensures that pro-life Americans will not be forced to fund, enable, or facilitate the killing of unborn children and the wounding of their mothers.
Supermajorities, more than 67 percent, oppose public funding of abortion. Protecting vulnerable unborn children and women from the insidious violence of abortion is the human rights cause of our time.

So please let’s not gloss over or trivialize the fact that abortion dismembers, decapitates, starves to death, or chemically poisons innocent babies, and that the abortion act itself, euphemistically called “choice,” can in no way be construed to be compassionate, benign, nurturing, or health care. Abortion is violence against women and children. It is neither health care nor reform.

Support the Stupak-Pitts amendment.

Mr. WAXMAN. Mr. Speaker, I continue to reserve the balance of my time.

PARLIMENTARY INQUIRY

Mr. BARTON of Texas. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman with the inquiry.

Mr. BARTON of Texas. Who has the right to close this part of the debate? Does Chairman WAXMAN have the right to close or does the ranking minority member have the right to close?

The SPEAKER pro tempore. There is only one overall right to close, and that will be the majority manager.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to Congressman JEB HENSARLING from the great State of Texas for 1 minute.

Mr. HENSARLING. Mr. Speaker, government-run health care is government-rationed health care. Today in America when our loved ones need health care, they wait hours, maybe days; but in Britain and Canada, they wait weeks, months, perhaps even a year.

Mr. Speaker, since I have been age 5, I have gone fishing with my father. Those are moments I treasure. But 15 years ago he went to see his doctor about a chest pain; 48 hours later, he had triple bypass surgery. And guess what? At age 81, we are still fishing. But had he been in Britain, had he been in Canada, there might never have been another fishing trip. My children might have never known their grandfather because health care delayed is health care denied.

Government-rationed health care will mean our loved ones will suffer. They will languish, and perhaps even perish. We should never support a children-bankrupting, health care-rationing, freedom-crushing $1 trillion government takeover of our health care system.

Let’s support the Republican plan to give the American people the health care they need, when they need it, at a price they can afford.

Mr. BARTON of Texas. Mr. Speaker, I would like to recognize a Member from the great State of Georgia (Mr. KINGSTON) for 1 minute.

Mr. KINGSTON. Mr. Speaker, in January, with unemployment at 8.5 percent, Speaker PELOSI passed an $800 billion pork-laden stimulus bill that was supposed to create jobs. In May, with unemployment up to 9.5 percent, Speaker PELOSI passed an energy tax of $1,500 per household across America that was supposed to create green jobs. Now in November, unemployment is up to 10.5 percent, we have the highest deficit in the history of the country, a $12 trillion national debt, and Speaker PELOSI has placed on a government takeover of insurance.

This bill raises premiums. It raises taxes. It cuts Medicare, and it forces you to surrender your current health care coverage and puts a thousand bureaucrats in between you and your doctor.

The government couldn’t even run Cash for Clunkers, and now it wants to take over 17 percent of the economy.

Let’s vote “no” on the Pelosi plan and support the bipartisan alternative.

The SPEAKER pro tempore. The gentleman from Texas has ½ minutes. The gentleman from California has 30 seconds.

Mr. BARTON of Texas. Mr. Speaker, I yield myself the balance of the Energy and Commerce time.

Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.

Mr. BARTON of Texas. Mr. Speaker, first of all, let me tell you how proud I am of the members of the Energy and Commerce Committee on both sides of the aisle who have participated in this debate since January, and who have participated on the floor debate today. It makes me proud to be a member of that committee.

Mr. Speaker, we have heard all of the policy arguments pro and con for this bill. I am going to end the Republican side of the Energy and Commerce debate simply by saying that I think this bill should be defeated because it is an imposition on personal freedom here in America. I just simply don’t think that it is right to tell people that they have to have insurance, tells employers they have to provide insurance, to set up a bureaucracy that advises a bureaucracy what that insurance should be, that then determines what the insurance itself should be, what the minimum premium should be, what has to be covered, and then over time almost guarantees that everybody, except the richest people in America, are in some version of the public option.

I just think that is wrong in America, Mr. Speaker, and for that reason alone I am against this bill.

There is an alternative. The Republican alternative covers many of the things that my friends on the majority side say they are for. We simply do it without mandating and imposing government on the American people. Please vote “no” on the majority bill, and vote “yes” on the minority substitute.

Mr. WAXMAN. Mr. Speaker, 37 million Americans do not have health insurance because they can’t afford it, or they have a preexisting condition and the insurance companies deny it to them. We want them to buy the same policies that good people have bought. Often it is easiest to think about people with preexisting conditions who are uninsured as the poor, the sick, or the jobless.

Mr. Speaker, the face of the uninsured stands before this House today in Florida (Ms. WASSERMAN SCHULTZ). Ms. WASSERMAN SCHULTZ. Mr. Speaker, we have heard a lot of discussion in this debate about the uninsured and the uninsurables. Often it is easiest to think about people with preexisting conditions who are uninsured as the poor, the sick, or the jobless.

Mr. Speaker, the face of the uninsured stands before this House today in south Florida. Ms. WASSERMAN SCHULTZ. Ms. WASSERMAN SCHULTZ. Mr. Speaker, we have heard a lot of discussion in this debate about the uninsured and the uninsurables. Often it is easiest to think about people with preexisting conditions who are uninsured as the poor, the sick, or the jobless.

Ms. WASSERMAN SCHULTZ. Mr. Speaker, we have heard a lot of discussion in this debate about the uninsured and the uninsurables. Often it is easiest to think about people with preexisting conditions who are uninsured as the poor, the sick, or the jobless.

It is time to deliver on the American promise not just of liberty, but justice for all.

Mr. CAMP. Mr. Speaker, I yield myself 2 minutes.

Republicans have listened to the American people. It is clear from the Speaker’s health care bill the Democrats have not. The Speaker crafted this bill behind closed doors and added 1,000 pages that have never been before a committee or had any input from the American people. Just yesterday we confirmed that Americans could face 5 years in jail if they don’t comply with the bill’s demands to buy approved health insurance, and who knows what else we will discover over time. Simply put, the health care of the American people is too important and too complex to risk on this gigantic gamble. This bill will do lasting damage to our economy and
force millions of Americans to give up their current health care coverage.

With the national unemployment rate spiking to 10.2 percent, it should be unthinkable to pass this bill which contains more than $730 billion in taxes that will take away millions more American jobs. The Democrats’ bill cuts Medicare by one-half trillion dollars, slashing health care benefits for seniors, a direct violation of the President’s pledge that Americans could keep what they have if they like it.

The Democrats’ bill, when paired with an unpaid-for SGR fix, increases the deficit, a violation of the President’s pledge that health care reform would not add one dime to the debt. The Democrats’ bill drives up the cost of health care and increases Federal spending on health care by $600 billion, a violation of the President’s pledge that health care reform would bend down the cost curve.

So you can’t keep what you like if you buy what you get. This bill spends over $1 trillion while raising taxes, cutting Medicare and increasing the deficit, and it drives up the cost of health care. The Democrat majority has not listened to the American people. Vote “no” on this bill.

Mr. RANGEL. Mr. Speaker, I would like to recognize the distinguished gentleman from Georgia (Mr. SCOTT) for 1 minute.

Mr. SCOTT of Georgia. Mr. Speaker, today the arc of history will hover over this House of Representatives, and the question facing each and every one of us today as 14,600 of our American citizens are losing their insurance every day is: where are we going to stand on this arc of history today? I ask you, are you going to stand with the negative forces of “no” or “kill the bill” or “I object”? Or are we going to stand with the hope of America that has been expressed all of the way down from Teddy Roosevelt to John Kennedy to Harry Truman to Lyndon Baines Johnson to Teddy Kennedy, and to JOHN DINGELL?

I say to you today, this House of Representatives, stand up and say I am not afraid of the future because the key to our future is to make sure that all Americans have access and have affordable health care insurance. That’s what the American people are expecting us to do, to stand up for America.

Mr. CAMP. I yield to the gentleman from California for a unanimous consent request.

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

Mr. ROHRABACHER. Mr. Speaker, I oppose this bill that will take hundreds of billions of dollars out of Medicare and give billions of dollars of health care to illegal immigrants.

Mr. Speaker, this attempt at slashing Americans into dependence on a government-controlled health care system brings bait and switch to a new low.

We have heard about the flaws of our current healthcare system, high costs, lack of portability, lose a job—lose health insurance, discrimination of those with preexisting conditions. Yes, many of the heart-wrenching stories we are hearing to justify this legislation are real. But correcting those maladies requires specific reform, not transforming healthcare into an bureaucratically-managed system that will cost hundreds of billions, including billions to provide healthcare for illegal aliens, while at the same time cutting Medicare by hundreds of billions of dollars. This so-called reform will destroy the freedom of the American people to make health decisions with a doctor of their choice. It will transform our system, rather than reform it. And what we will end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

You can touch our hearts with the stories of suffering brought about by defects in our current system, but it doesn’t follow that we have to buy into this monstrous federal power grab. It is too benign to call this scheme bait and switch.

Wake up America!

This bill cuts healthcare for our seniors by hundreds of billions of dollars while providing a heavily-subsidized health-care system for illegal immigrants, which will draw more illegals into our country. Wake up America!!

This bill is structured so that private companies will find it profitable to dump employees into the government-run option, rather than continuing to offer private health insurance.

Wake up America!!

This ill-conceived power grab will bankrupt our country as it destroys our freedom.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, a true American hero, the gentleman from Texas (Mr. SAM JOHNSON).

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, today we are voting on Speaker PELOSI’s $1 trillion Wash-ington takeover of health care. This bill bulldozes individual liberty and puts the government just where it doesn’t belong, right smack dab in the middle of your personal health care decisions. This bill forces every single person in this country to purchase government-approved health care or go to jail. Businesses must also offer government-approved health care or face hundreds of billions of dollars in job-killing taxes.

Unfortunately, government-approved health care will be defined by a handful of bureaucrats around a conference table in Washington. This unprecedented Washington power grab eliminates an individual’s right to choose what kind of health care is best for them and their families.

Speaker PELOSI’s 20-pound, 2,000-page bill costs $2.2 million per word. The American public have made their voices heard. They are sick and tired of the government sticking its nose where it doesn’t belong. They are fed up with Washington’s trillion-dollar bailouts, free handouts and special interest paybacks.

The Democrats in Congress need to listen and come up with a bipartisan, patient-centered plan. We can do better with a targeted, fiscally responsible approach that makes health insurance more affordable, more accessible, and available. Real health reform protects our right to choose our own care. Real health reform gives doctors the freedom to do what is best for their patients. We can do all of this without piling trillions of dollars of debt onto our children and grandchildren.

Wake up America!!

While I would have preferred a single-payer system, I am happy to support a bill that contains a public health insurance option that will provide competition to the private insurance companies and will drive down rates.

This bill will end discrimination against people with preexisting health conditions, will end the practice of dropping patients when they are sick, and will strengthen and enhance Medi-care by ending the doughnut hole and extending the solvency of the Medicare Trust Fund.

Mr. Speaker, the status quo is not an option. We have an opportunity to get universal health care coverage in this country to implement the competitive public health insurance option that puts the patient before the quarterly financial report, and to ensure that just because you lose your job, you won’t lose your health insurance.

This is monumental and historic, and I am proud to support the Affordable Health Care for America Act.

Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and universal health coverage. This historic bill, H.R. 3962, makes great strides toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage. Families go to sleep at night knowing that they are one serious illness away from bankruptcy. And the unemployed are people who face going it alone in the prohibitively expensive individual coverage market or, worse, going without insurance at all.

Vote down this deficit-ballooning, job-killing, Washington takeover of health care today.

Mr. RANGEL. Mr. Speaker, I would like to recognize my friend and colleague, the outspoken Member from New York, Mr. NADLER, for 1 minute.

(Mr. NADLER of New York asked and was given permission to revise and extend his remarks.)

Mr. NADLER of New York. Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and universal health care coverage. This historic bill goes a long way toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage. Families go to sleep at night knowing that they are one serious illness away from bankruptcy. And the unemployed are people who face going it alone in the prohibitively expensive individual coverage market or, worse, going without insurance at all.

Wake up America!!

While I would have preferred a single-payer system, I am happy to support a bill that contains a public health insurance option that will provide competition to the private insurance companies and will drive down rates.

This bill will end discrimination against people with preexisting health conditions, will end the practice of dropping patients when they are sick, and will strengthen and enhance Medi-care by ending the doughnut hole and extending the solvency of the Medicare Trust Fund.

Mr. Speaker, the status quo is not an option. We have an opportunity to get universal health care coverage in this country to implement the competitive public health insurance option that puts the patient before the quarterly financial report, and to ensure that just because you lose your job, you won’t lose your health insurance.

This is monumental and historic, and I am proud to support the Affordable Health Care for America Act.

Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and universal health coverage. This historic bill, H.R. 3962, makes great strides toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage, with another 14,600 Americans joining the ranks of the uninsured each day. We see families who go to sleep at night knowing they are one serious illness away from bankruptcy, the reason...
CONGRESSIONAL RECORD — HOUSE
November 7, 2009

H12852

for 55 percent of all bankruptcies filed last year. We see the rising ranks of the unemployed who face going it alone in the prohibitively expensive individual coverage market—or worse, going without insurance at all. And we see 20,000 people die every year because of health insurance.

At the same time that this stark reality hits hardworking Americans, insurance companies have conspired to keep costs high. These costs, upward of 15–35 percent squandered on outrageously high administrative costs, do nothing to make people healthier but do much to line the pockets of insurance companies and help their corporate bottom line.

This is unacceptable. We must take action. That's why I support the Affordable Health Care for America Act.

As with any legislation, there have been some compromises made along the way. I would have preferred a single payer system, the most effective and least costly way to implement a health delivery system. But I, like so many of my colleagues, have come to see a competitive public option as the best available way to break the failed health care approach. A public option will put patients and doctors, not corporate bottom lines, at the forefront. This public option will add much needed competition into an insurance market that must be kept honest, and it will work to drive down costs.

Mr. Speaker, this past August, political pundits and TV-talking heads had the public option dead on arrival. Yet, because of the efforts of progressive Members in Congress, in which I was proud to join, we succeeded in keeping the public option in this bill and ensure that the American people would be given an alternative to corporate health insurance. And make no mistake about it—the public option weathered the storms of misinformation, slander, and downright lies because the American people saw through the political game playing and saw the public option for what it is—an option, not a mandate, that will help stem the cost of ever-rising health care costs.

In addition to the public option, this national health reform bill implements key insurance industry reforms, strengthens Medicare, and immediately gives hope to the millions of Americans currently living without health insurance. It will end discrimination against pre-existing conditions, and end the cruel practice of rescission, which allows insurance companies to drop people from coverage if their illness is considered too expensive. This bill also guarantees that people with insurance will not face devastating costs when they get sick by placing limits on out-of-pocket medical expenses, and creates for the first time voluntary long-term care program. And H.R. 3962 would end the blanket exemption insurance companies currently enjoy from anti-trust laws.

With this change, we can now bring anti-trust enforcement against the egregious practices of price-gouging major health insurance.

H.R. 3962 contains numerous provisions that help our seniors by strengthening and enhancing the Medicare program. This bill reduces the donut hole to $500 immediately and eliminates it entirely by 2019. It allows the HHS secretary to negotiate prescription drug costs, which I have long advocated for. It eliminates out-of-pocket expenses for preventive care for seniors, and extends the solvency of the Medicare trust fund for at least five years.

Small businesses also receive desperately needed assistance from this bill. Initially, businesses with up to 25 employees, then growing to businesses with up to 100 employees by 2015, will be able to join the health exchange, which will allow small business employers to take advantage of group rates and a broader range of insurance options. For everyone, they change that will go a long way toward helping small businesses keep down their number one expense, which is the cost of providing health care coverage.

For America’s young people, who make up 29 percent of the uninsured in America, H.R. 3962 will permit parents to extend coverage to their children until their 27th birthday. To help American families defray the costs of health coverage, this bill extends assistance on a sliding scale to families earning up to $88,000 per year. This will go a long way toward ending the cruel choice between health care coverage and other necessities.

Mr. Speaker, there are some who have said that health care reform is too hard. There are those who have allowed misinformation and politics to push them to root against helping their fellow Americans to have access to quality, affordable health care. There are even those who, for reasons I fail to grasp, want to continue with the status quo.

To those people, Mr. Speaker, I say—the status quo is not an option. We have a remarkable opportunity in front of us. We have an opportunity to make fundamental changes to the way we view health care and deliver services, to implement a competitive public health insurance option that puts the patient before the quarterly financial report. And, with passage of this bill, we will be able to say for the first time in this country that just because you lose your job, you won't lose your health insurance.

Mr. Speaker, this is monumental. This is historic. And I am proud to cast my vote in favor of the Affordable Health Care for America Act.

Mr. CAMP. At this time, I yield 2 minutes to the distinguished gentleman from the Ways and Means Committee, the gentleman from Texas (Mr. Brady).

Mr. BRADY of Texas. Mr. Speaker, this is the Pelosi health care plan, and it's wrong for America. Over 100 new Federal agencies, commissions, and mandates standing between you and your doctor. This huge, inefficient new bureaucracy makes your health care insurance more expensive, forces millions of Americans into a government-run plan, raises taxes on workers and small businesses, increases Medicare drug costs for seniors, adds an oafish, frightening deficit, and after throwing $1 trillion at the problem, still leaves 18 million Americans uninsured. Big government doesn't mean better health care.

To pay for this massive new bureaucracy, Democrats slash Medicare for our elderly by a half-trillion dollars. That means 600,000 Texas seniors are going to lose their plan. It shut 40 doctor-owned hospitals in Texas, costing us 15,000 jobs. And 1.5 million Texans will have their plans disappear.

This is not the reform families need. Instead, this is all about taking the giant first step toward a single-payer national health care system. If the Pelosi plan passes, Washington will ultimately decide which doctors you can see, what treatments you deserve, and what medicines you receive, and when you're sick, will you be worth their cost?

House Republicans have a different vision. We listened. Ours is a careful, step-by-step solution to the complex issue of health care, focusing first on lowering your health care costs so you can afford it. For example, Tax Increases, no Medicare cuts, no rationing, no mandates, no huge intrusion of government into the most intimate parts of your health care, just more choices, more fairness, less lawyers.

Best of all, our Republican plan is the only reform that actually lowers your health care premiums and lowers the deficit.

We need to get health care reform right the first time. The Pelosi plan is wrong.

Mr. RANGEL. Mr. Speaker, for another view of health care in Texas, I yield 1 minute to Ms. JACKSON-LEE.

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, today I am holding up a concise, efficient, and effective health care plan for America, H.R. 3962, and I plan to stand with America and those who support it. As we cast our vote for affordable health care for America.

Eighteen thousand people die every year because they do not have health insurance. The State of Texas has 6 million people who don't have health insurance. Several Republican Members from Texas, have in their districts, some 29 percent, and 18 percent of individuals who don't have health insurance.

Today I rise to say that the plan we have will immediately close the doughnut hole for Seniors. It will provide the uninsured with a bridge to the exchange program. It will extend the coverage for our young people until the age of 27, and, yes, I'm proud of the language on pages 22 and 23 that will begin to help save hospital beds in physician-owned hospitals in the State of Texas and around the Nation. This language is in the bill and we now can work to work to competently qualify hospitals in rural and urban areas.

We are ready to fight. We are ready to make sure that those who need health insurance will have us on their side. I am standing with America and voting for America for the first time in what a health care insurance bill passes the House with a Public Option to give more access to Americans and lowers the costs of health care insurance. Vote for the health care bill now.

I yield before you today in support of H.R. 3962, the Affordable Health Care for America Act. On July 5, 1965, President Lyndon Johnson said the following about the passage of Medicare, “This bill is sweeping in its intent
and impact. It will help pay for care in hospitals. If hospitalization is unnecessary, it will help pay for care in nursing homes or in the home. And wherever illness is treated—in the home or hospital—it will also help all Americans. My friends we can all say that about this sweeping legislation. Madame Speaker, while working as a pediatrician I cared for uninsured children, and those enrolled in SCHIP and Medicaid. What everyone enjoys about working within that system was that they provided high quality care to the dysfunction of our health care system. Dr. Alex also related another interesting paradox that I’ll share with you. He tried his hardest to make this bureaucrat understand the child’s bloody scabs, the mother’s tears. But to no avail. The dermatologist took pity on the child and did what we physicians often do, he saw the patient for free. Why, he asked the insurance bureaucrats to come between Dr. Alex and his patients? We can do better than allow profit driven bureaucrats to decide what medicines my patients receive. He wants a health care system where we health care providers do not have to worry whether their insurance company will pay for it. An insurance bureaucrat sitting in their cubicle should play no part in the relationship between me and my patient. We need to reform our system.

Today is a historic day not only for the 39 million uninsured Americans, but also for our great nation. As Speaker Pelosi remarked earlier today, we, Members of Congress, are "humbled to stand here at a time when we can associate ourselves with the work of those who passed Medicare, and now we will pass health care reform." Many parallels exist between that history and today. Today, we listened to a parade of Republicans warn that this bill will bring the downfall of American society, of the American way of life. This is not the first time that the Republicans have been on the wrong side of history. In an interview in 1975, David L. Kopelman, who played a prominent role in the early administration of the Medicare Program, remarked that his colleagues were often critical of the program and called it "a communist scheme foisted on the American people." Alf Landon, the Republican candidate for President in 1936, even campaigned on the fact that not a dollar in social security benefits would ever be paid. Mr. Speaker, unfortunately, such ad hominem attacks are as prevalent as ever. The Republicans want you to believe that our country is descending into an abyss of socialism, but nothing could be further from the truth. Today, I am proud to support a bill that is distinctly American. We the people, Thomas Jefferson wrote in the Declaration of Independence are endowed with certain unalienable Rights that among these are Life, Liberty and the pursuit of Happiness. —That to oppose this bill I know otherwise. Today, I met with dozens including physicians, medical students, patients, and advocates. This group included representatives from Doctors for America, National Physicians Alliance, American Medical Student Association, US PIRG, Disciples of Christ, Episcopal Church, NETWORK — A Catholic Social Justice Lobby, United Church of Christ, and United Methodist Church along with a nationally renowned cardiac surgeon Dr. Salim Aziz of the George Washington University Medical Center. The health providers with whom I met are on the front lines of the health care debate every day. As such, it is no surprise that they enthusiastically endorse this bill, while holding out hope for progressive changes to the reform legislation before it becomes law. These health professionals see the pain and frustration of hardworking Americans who face financial collapse, physical suffering, and sometimes the loss of their life simply because they do not have health coverage.

Allow me to share with you some of the stories that I’ve heard from these care givers. One story was that of Dr. "Alex", a Pediatrician and Health and Evidence Policy Fellow at Mt. Sinai School of Medicine. Dr. Alex told me of an uninsured 13-year-old boy who had a swollen face covered in a rash on his forehead and cheeks, and raw in his neck folds. He sat before him and scratched his arms, trunk, and face uncontrollably to the point of bleeding. Because of his constant scratching his skin had started to harden. He had eczema and his mother told him in tears how she had not been able to obtain a referral to a dermatologist. The county pediatric dermatologist’s one afternoon a month clinic time was that same day. To prevent the patient’s mother from receiving a large medical bill, Dr. Alex did what he normally did; he got on the phone to his private insurance company and asked the insurance bureaucrat to agree to pay for the visit. As his other patients had to wait for him, he wasted time on the phone trying to solicit preapproval from her insurance company. But what could a social worker do? He tried his hardest to make this bureaucrat understand the child’s bloody scabs, the mother’s tears. But to no avail. The dermatologist took pity on the child and did what we physicians often do, he saw the patient for free. Why have we allowed insurance bureaucrats to come between Dr. Alex and his patients? We can do better than allow profit driven bureaucrats to decide what medicines my patients receive. He wants a health care system where we health care providers do not have to worry whether their insurance company will pay for it. An insurance bureaucrat sitting in their cubicle should play no part in the relationship between me and my patient. We need to reform our system.

Today is a historic day not only for the 39 million uninsured Americans, but also for our great nation. As Speaker Pelosi remarked earlier today, we, Members of Congress, are "humbled to stand here at a time when we can associate ourselves with the work of those who passed Medicare, and now we will pass health care reform." Many parallels exist between that history and today. Today, we listened to a parade of Republicans warn that this bill will bring the downfall of American society, of the American way of life. This is not the first time that the Republicans have been on the wrong side of history. In an interview in 1975, David L. Kopelman, who played a prominent role in the early administration of the Medicare Program, remarked that his colleagues were often critical of the program and called it "a communist scheme foisted on the American people." Alf Landon, the Republican candidate for President in 1936, even campaigned on the fact that not a dollar in social security benefits would ever be paid. Mr. Speaker, unfortunately, such ad hominem attacks are as prevalent as ever. The Republicans want you to believe that our country is descending into an abyss of socialist.
I will continue to work to save physician-owned hospitals that are currently treating patients or under significant development, to ensure that Americans can continue to receive healthcare at the local hospitals they have come to depend on. Physician-owned hospitals take care of patients covered by Medicare and Medicaid, as well as patients who are uninsured or cannot pay for their care. They also provide emergency departments access for their communities. At a time when we are concerned about the shortage of hospital beds, the face of epidemics like the swine flu, my amendment to this landmark bill will make sure no hospital is forced to shut its doors or turn away Medicare or Medicaid patients. The benefits that will come from our efforts to protect physician-owned hospitals far outweigh the potential losses to local economies. Not only do physician hospitals deliver high quality medical care to the patients they serve, they also provide much needed jobs, pay taxes, and generate significant economic activity for their communities and businesses. Existing physician-owned hospitals employ approximately 51,700 individuals, have over 27,000 physicians on staff, pay approximately $2,421,579,312 in payroll taxes, and $508,895,167 in federal taxes, and have approximately $1.9 billion in trade payables. Hospitals currently under development would employ approximately 21,700 more individuals. With approximately 50 physician-owned hospitals, Texas leads the nation in the number of physician-owned hospitals. The Texas economy could lose more than $2.3 billion and more than 22,000 jobs.

In my district, the 18th Congressional District of Houston, Texas, St. Joseph Medical Center is a general acute care hospital that treats everyone. In fact, 40 percent of those in the Medicaid patient population is double the average hospital's patient population in the entire State of Texas and is one of the highest in the country. St. Joseph's was operated by the Sisters of Charity for many years until it was scheduled to be closed by the HCA. It could no longer support it. The hospital was offered to for-profit and not-for-profit hospital systems but no one would accept responsibility for operating St. Joseph's. A plan was developed to convert the hospital into a dominion-owned facility that was initially supported. It was only at that point that the physicans who had practiced there for many years came together to buy the hospital to save it from closing.

St. Joseph's takes care of patients covered by Medicare and Medicaid, as well as patients who are uninsured or cannot pay for their care. The emergency departments of many physician-owned “specialty hospitals” have been criticized for not having a true emergency room. St. Joseph’s had a hospital development which is open 24 hours per day, 7 days per week, providing an access point for patients in need of emergency services. In fact, St. Joseph’s admissions through the emergency department are double the State average.

St. Luke’s hospital in Houston, which is church-owned, has three new facilities under development; the nonprofit religious mission has the controlling interest. One full-service hospital has one phase already operating, but would be under the growth restrictions; the hospital cannot be completed if the new restrictions apply. The hospital brought approximately 300 new jobs to the community; and Baylor Health Care System, based in Dallas, has found that their partnership with physicians has increased measurable quality, increased patient satisfaction, and decreased the cost in the delivery of their excellent care. This joint venture model has produced a heart hospital among the nation’s lowest complication rates in the entire United States. And yet this bill would deny Baylor Health Care System the right to add a single operating room or procedure room to meet its community’s need. During the moratorium on physician-owned hospitals, Baylor Health Care System was forced to add a badly needed OB/GYN service at its Frisco, Texas, hospital. This service is a money losing service, but there was no such service within many miles for those people—Baylor fulfilled the need. It was prohibited from adding this service simply because the hospital had physicians holding a majority of the ownership of the hospital. After the moratorium was lifted, the service was added and is currently working at its capacity. Mr. Speaker, can we imagine witnessing an impact, of no patient beds, 6- to 8-hour waiting times, 12 hour- to 24-hour waiting times, turning emergency patients away at the door? Can we imagine the dramatic case, when patients are not able to access quality care? This is true of the most serious trauma, of the most serious medical cases. Physicians own or own very many cases at least 40 percent of the city’s population. I don’t just mean the city’s population. We are discussing a population that is between 500,000, which is the indigenous population, and the population of 1.5 million that’s in the city every evening.

When a hospital downsizes in a particular city, it extends beyond the boundaries of that city, and in doing so, with this hospital being downsized, it’s impacting all of the hospitals, not only in the city, but those hospitals in nearby jurisdictions. We’re seeing the epicenter of a catastrophic event, and unless we realize the importance of this one medical facility, but look at it not from the perspective that it serves this city, but we have to realize that it serves the world. It serves the Nation. For the very least, it serves the Nation; at the very most, it most serves the world. So when you start looking at it from those perspectives, then it becomes more than just a problem of Houston, Texas, but a problem of this Nation. And it should be addressed in that manner.

If we do not work closely together to look deeper at this issue, we will face a number of medical facility closures that is a disservice to the American people. So, we see that there seems to be a phasing-back or cutback in all of the major services, but the most important need step into any emergency room on any day, at any time, and just see the impact of this one hospital being downsized. The impact will reach out throughout the city of Houston. Again, a true indication of the success of any city government, or any country, is its ability to care for its weak, its injured, its sick, its young, and its old. The ability to care—compassion. Let us be honest—we see the faces of those individuals who we cannot help, because the system has failed them, and they ask us for help. What do we tell them? You never want to lie to a patient. You want to be honest and up-front with this patient. But you reach a point where, in some cases, it’s best that you say nothing.

How can we tell a family member sitting across from me, in the back of my ambulance, with their loved one lying on the cot as we do CPR, cardiopulmonary resuscitation, on them, “I’m sorry, we’re going to have to go on the other side of the city because St. Joseph’s Hospital is closed?” Then, when we get there, the doctors come to the family member and say, “I’m sorry, your husband, your son, your daughter, your child, has died.” How do we explain that to them? We passed the hospital that may have made the difference in this case. The ability to care, to show compassion: It’s just apparent to me that that just doesn’t exist now. To sign off on anything less is to simply say, we turn our back on others' need.

This is a national problem, but we should be setting the trend, we should set the example for the entire Nation that hospitals like St. Joseph’s Hospital do more than just care for our sick and injured. They represent our capacity to care. There is a duty to care and a passion to care.

H.R. 3962 is a bill that will change the health dynamics positively for all Americans—but it is a work in progress. In the manager’s amendment after weeks of meetings with the leadership our efforts to seek some relief for physician-owned hospitals was achieved. It is not a winning formula, however on pages 22–23 of the manager’s amendment we secured language that says that all physician-owned hospitals should not be forced to close. We have introduced two amendments to cover extending the grandfathering of physician-owned hospitals and on criteria for other physician-owned hospitals. However, our work is not finished—we must work with the Senate and in conference to keep quality health care.

For the RECORD, I have attached a chart on Texas uninsured, benefits for the 18th Congressional District, and physician-owned hospitals.

This is a vital issue which must be corrected or the bill moves through Congress and for physician-owned hospitals to survive and grow. Martin Luther King, Jr. often told the story of the priest, the Levite and the good Samaritan. “The first question that the priest and Levite asked was ‘If I stop to help this man, what will happen to me?’ But, the Good Samaritan reversed the question ‘If I do not stop to help this man, what will happen to him?’ Today, we can be the Good Samaritan—to help all Americans access good health care. Finally a special thanks to Chairman RANGEL, WAXMAN, and MILLER, very, very thank you to Congressman JOHNGELL and the late Senator Edward M. Kennedy.
No insurance, Texas has the highest rate of uninsured with about 6 million uninsured. Texas Districts with the highest percentage of uninsured constituents. Rank shows district ranking out of 435 national districts. Rank, Representative, district No., and percent uninsured:

1. Ruben Hinojosa, District 15—46.4 percent.
2. Gene Green, District 29—36.4 percent.
3. Henry Cuellar, District 28—34.1 percent.
4. Silvestre Reyes, District 16—33.3 percent.
5. Eddie Bernice Johnson, District 30—32.3 percent.
6. Sheila Jackson Lee, District 18—29.7 percent.
7. Solomon Ortiz, District 27—28.6 percent.
8. Louie Gohmert, District 1—28.9 percent.
9. Joaquin Castro, District 20—27.3 percent.
11. Ron Paul, District 14—23.7 percent.
13. Lamar Smith, District 21—18.3 percent.
14. Lloyd Doggett, District 25—25.0 percent.
15. Carol Chumney, District 12—18.2 percent.
16. Louie Gohmert, District 1—28.9 percent.
17. Bill Flores, District 17—28.8 percent.
18. Gene Green, District 29—36.4 percent.
19. Sheila Jackson Lee, District 18—29.7 percent.
20. Jeb Hensarling, District 5—26.8 percent.
22. Gene Green, District 29—36.4 percent.
23. Louie Gohmert, District 1—28.9 percent.
24. Lloyd Doggett, District 25—25.0 percent.
25. Joaquin Castro, District 20—27.3 percent.
27. Solomon Ortiz, District 27—28.6 percent.
28. Louie Gohmert, District 1—28.9 percent.
29. Joaquin Castro, District 20—27.3 percent.
30. Carol Chumney, District 12—18.2 percent.
31. Bill Flores, District 17—28.8 percent.
32. Gene Green, District 29—36.4 percent.
33. Sheila Jackson Lee, District 18—29.7 percent.
34. Jeb Hensarling, District 5—26.8 percent.
35. Tony Gonzales, District 23—26.9 percent.
36. Gene Green, District 29—36.4 percent.
37. Lloyd Doggett, District 25—25.0 percent.
38. Carol Chumney, District 12—18.2 percent.
39. Bill Flores, District 17—28.8 percent.
40. Gene Green, District 29—36.4 percent.
41. Louie Gohmert, District 1—28.9 percent.
42. Joaquin Castro, District 20—27.3 percent.
43. Ciro Rodriguez, District 23—26.4 percent.
44. Solomon Ortiz, District 27—28.6 percent.
45. Louie Gohmert, District 1—28.9 percent.

The Affordable Health Care for America Act in the 18th Congressional District of Texas

The Affordable Health Care for America Act will make health care affordable for the middle class, provide security for seniors, improve Medicare for 70,000 beneficiaries, improve employer-based coverage for the uninsured—while responding to the federal deficit. There were 500 health care-related bankruptcies in the district in 2008, caused primarily by the health care costs not covered by insurance. The bill’s insurance reforms, they will now be able to purchase affordable coverage. The Affordable Health Care for America Act will make health care affordable for the middle class, provide security for seniors, improve Medicare for 70,000 beneficiaries, improve employer-based coverage for the uninsured—while responding to the federal deficit. The bill’s insurance reforms, they will now be able to purchase affordable coverage.

Mr. RANGEL. Mr. Speaker, I rise today to support a bipartisan bill to fix what’s broken in health care. This is about ideology. If we are going to make this in body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent. Yes. Does this bill mean the government will take over running our health care system? Yes. But what is worse is this bill replaces the American idea with a European-style social welfare state. This bill, more than any other decision we are going to make in this body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes.

Mr. RANGEL. Mr. Speaker, I rise today to support a bipartisan bill to fix what’s broken in health care. This is about ideology. If we are going to make this in body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes. Does this bill mean the government will take over running our health care system? Yes. But what is worse is this bill replaces the American idea with a European-style social welfare state. This bill, more than any other decision we are going to make in this body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes.

Mr. RANGEL. Mr. Speaker, I rise today to support a bipartisan bill to fix what’s broken in health care. This is about ideology. If we are going to make this in body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes. Does this bill mean the government will take over running our health care system? Yes. But what is worse is this bill replaces the American idea with a European-style social welfare state. This bill, more than any other decision we are going to make in this body, will do more to put millions of Americans as dependents on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes.
their opposition to government-run health care known. They have come out by the thousands to town halls, called our offices, and held peaceful rallies, but, unfortunately, congressional Democrats have refused to listen.

The legislation being considered today is one of the most damaging, destructive bills ever to come before this Chamber. A government takeover of health care won’t bring down cost, but it will bring down quality of care. It will add billions of additional debt at the expense of future generations. It raises taxes by $750 billion and guarantees middle class tax increases down the road.

We all agree that we need health care reform, but we don’t need to put the government in charge. Mr. Speaker, I believe in the free market, I believe in choice and competition, and I believe in freedom to choose your doctor and to get the treatments you need. America was built on these principles, and the Pelosi health care plan will take us in the opposite direction.

I urge every Member of the House to live up to our obligation, listen to the people and say “no” to government-run health care.

Mr. RANGEL. I yield myself 30 seconds, Mr. Speaker, because the gentleman who just spoke said that the Democrats didn’t listen to the Republicans. Having had the honor to serve with outstanding Republicans on the Ways and Means Committee and having, as chairman, had hearings last year and throughout, quite frankly, there wasn’t much to listen to until last Tuesday when, for the first time, you presented a bill. In any event, I appreciate the gentleman’s contribution.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. RANGEL. I yield myself such time as I may consume.

We have been designated as one of the three committees to work on this bill for the President and for the House of Representatives. And we were privileged to work with Chairman Waxman as well as Chairman MILLER. I don’t think in the history of the Congress we have found three separate committees working in such cooperation. But as I said earlier, we had such hardworking, dedicated members and such a strong support staff that it’s almost embarrassing to me not to think of things we can share with you the work and the time and support that they’ve given to this important issue for the Congress and for our country.

In any event, I have to admit, as Chair, there was one member that I relied on most. He is the gentleman from California who since 1984 served and continues to serve as the chairman of the Health Committee. And so it is with a great deal of pride that I yield 3 minutes to the gentleman from California (Mr. PETE NUNES).

Mr. STARK. Mr. Speaker, today’s vote will be the most important of our careers. History will mark which side we’re on: providing quality, affordable coverage for all Americans, or the status quo.

I would remind my friend from Wisconsin that former Senator Bob Dole voted against Medicare, and that vote has haunted him ever since. It probably prevented him from becoming President.

Since my first election, I have worked to see that government serves our people. My top priority for 37 years has been to provide quality, affordable health care. I have done what I could, but I learned that sooner it is done, but it is hard, but at my age, you learn to take what you can when you can get it.

The bill is not the bill that many of us would have created on our own. That is the legislative process. The compromise before us today is the right thing to do for the American people.

The bill guarantees health coverage to 96 percent of Americans. It’s fully paid for. People who like their coverage may keep it. It reforms health insurance regulation and requires shared responsibility by individuals, businesses, and government. It assures that health care is affordable for lower- and middle-income families. It fills the Medicare prescription drug doughnut hole, and it provides free preventive services in Medicare.

It has the support of consumers, doctors, nurses, senior citizens, children, people with disabilities, farmers, and small business owners—organizations that represent virtually every segment.

In my district, like every other district, Republican or Democrat, I’ve got 67,000 uninsured people who will be helped; 8,000 people with preexisting conditions; 14,000 businesses will get tax credits; 8,300 seniors will have their health care needs covered by Medicare.

I urge every Member of the House to live up to our obligation, listen to the people and say “no” to government-run health care.
We spent $1 trillion to bail out banks, investment companies and car companies. We spent another $1 trillion on a stimulus bill that has yet to produce any jobs as promised. This record spending doesn’t count the omnibus spending bills that we had and the fact that we grew our budget to $3.6 trillion all in one year.

If this weren’t enough, we are being asked now to create a new trillion-dollar, government-run health care program that we can’t pay for the two existing government programs that we have today—Medicare and Medicaid. These two programs have at least $62 trillion in debt that this Congress refuses to recognize. Let me repeat that again: $62 trillion in debt that we face with our two existing government-run health care programs.

Mr. Speaker, with $1 trillion here and $1 trillion there, pretty soon, you are talking about real money.

What is left, or rather, despite all of this spending during record times of high unemployment, this bill will kill American jobs, exporting them overseas. In the meantime, our government leaders continue to run over and grovel to the Chinese to borrow more money to finance the spending.

Mr. Speaker, Rome is burning while this Congress fiddles. This Congress is so irresponsible, so reckless, it’s like watching a broke, drunk gambler continuing to double down, just trying to break even.

Vote “no.”

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair informs the House that the gentr</div>
conference, do I have your guarantee that your vote will be in favor of the Stupak language?

Mr. RANGEL. Well, I haven’t normally cut any deals with you as a Republican, but why don’t you talk to someone on your level in the House leadership as you have in the past?

Mr. BOEHNER. Reclaiming my time, Mr. Speaker.

Mr. RANGEL. You asked me a question.

Mr. BOEHNER. This is exactly the point I’ve been trying to make.

While the House is expected to take up the Stupak language later on this evening, language which would outlaw the taxpayer funding of abortion, it’s pretty clear that this could be a shell game that’s underway, that it gets to pass here in the House, helping to ensure that this bill passes; but we have no guarantees that when it comes back from conference that that language stopping the taxpayer funding of abortion will be in the bill.

Mr. RANGEL. All I am asking, as long as you have been here, have you ever had a Member—

Mr. CAMP. Regular order, Mr. Speaker. Regular order. No time has been yielded.

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York.

Mr. RANGEL. Have you ever gotten a guarantee like that from anybody since you have been here? No.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members will please direct their remarks to the Chair.

Mr. RANGEL. Mr. Speaker, it is my pleasure to yield 1½ minutes to Mr. THOMPSON of California. I thank him for the great contribution he has made to this bill that we present.

Mr. THOMPSON of California. Thank you, Mr. Chairman, for yielding.

Mr. Speaker and Members, for far too long too many Americans have not had access to quality, affordable health care. Because of this legislation, the millions of Americans who don’t have health care or who are struggling to pay their health care bills will be able to get the care they need when they need it. Families, small businesses, and individuals will save money.

There will be no copays or deductibles for preventive care services. If you change jobs, you can take your coverage with you. You will not be denied coverage for preexisting conditions and families won’t be bankrupted by high medical bills.

The bill will also help inject competition into the marketplace to help bring down the rising costs of health care insurance. The Medicare doughnut hole will be closed and the bill reduces the deficit by at least $30 billion over the next 10 years.

There is still a lot more work to be done, and we are going to fix the doctor reimbursement to ensure the best access for our seniors in regard to getting health care. Today is a historic day for all Americans. It moves us one step closer to quality, affordable health care for all Americans.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Ohio (Mr. TIBERI).

Mr. TIBERI. Mr. Speaker, the American people do not want their health care replaced by government-run health care.

This bill is flawed in many ways. It cuts benefits to seniors. It increases taxes. It’s the largest expansion of Medicaid ever at a time when State governments across our land are cutting services. It creates and extends 43 entitlement programs and 111 new offices, bureaus, commissions.

The Ohio State Medical Association that represents doctors in my district is opposed to the bill. They write, “Medicaid eligibility expansion is a troubling trend for the physician community as payment for these services often fails to cover the cost of providing care.”

They go on to say, the legislation “lacks many of the critical elements necessary for successfully reforming America’s health care delivery system and strengthening the physician-patient relationship.”

The bill does not address medical liability reform, which causes defensive medicine to spread. Medicare is cut by over $500 billion. Five million seniors could lose the coverage they have today. It turns out that you can’t keep what you have if you like it. In fact, one of three seniors in my district could lose the benefits they enjoy today.

I am also concerned about the negative impacts on small businesses and employers. Under the “pay or play” mandate in this bill, Mr. Speaker, $135 billion will be thrust upon employers. Under the “pay or play” mandate, Medicare is cut by over $500 billion. Five million seniors could lose the coverage they have today. It turns out that you can’t keep what you have if you like it. In fact, one of three seniors in my district could lose the benefits they enjoy today.

I am also concerned about the negative impacts on small businesses and employers. Under the “pay or play” mandate in this bill, Mr. Speaker, $135 billion will be thrust upon those businesses. This could cause over 5.5 million Americans to lose their jobs.

Mr. Speaker, we have a better way, a better alternative that will lower health care premiums, guarantee health care to affordable health care for those with preexisting conditions, allow States flexibility to provide more coverage, and protect the benefits of our seniors.

Americans deserve better. Mr. Speaker. There is a better way. Let’s reject this bill and start over.

Mr. RANGEL. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Nevada (Ms. BERKLEY) and thank her publicly for the great contribution she has made to this bill.

Ms. BERKLEY. I thank the chairman for his kind words and his leadership on this issue.

Mr. Speaker, I rise today in support of this historic piece of legislation that will expand health care coverage to millions of my fellow Americans.

The way we provide health care in this country is unsustainable. In Nevada, the cost of a private family health insurance plan is expected to grow from over $11,000 in 2009 to more than $19,000 10 years from now. If we do nothing, we will reach a point in this country where hardly anyone will be able to afford health insurance.

This bill is good for Nevada. Over 400,000 uninsured Nevadans will be able to get health insurance because of this bill. This bill is good for Nevada’s seniors. It closes the doughnut hole, eliminates copays for preventive services and extends the life of Medicare over 5 years.

The bill isn’t perfect. It doesn’t contain a provision to protect bone density tests that I fought for. And it doesn’t fix the Medicare physician payment system, and we must do both. But I support this bill today for the needed reforms that are included. They are very important. It’s a great first step.

Faye Schwartz in Las Vegas, Nevada, this vote is for you.

Mr. CAMP. At this time I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. BROWN-WAITE. Mr. Speaker, the bill before us creates 111 different offices, bureaus, commissions, programs and entitlements, but it only cuts one—Medicare. This bill steals more than $500 billion from our Nation’s seniors to fund new entitlement programs for the young, the healthy and the wealthy.

My colleagues in the majority have boldly decided that cutting $500 billion from Medicare is a good idea. They actually are telling seniors that these cuts will improve Medicare in the future.

Well, Grandpa and Grandma might be old, but they are not stupid. You are not going to cut Medicare and tell them that it’s a good thing. The fact is this bill is not real reform. Congress should be strengthening Medicare, not weakening the program. Just look at how bad the Federal Government has been historically in predicting health care costs. This bill will increase health care costs for all Americans and cut Medicare funding. Americans don’t believe that yet another trillion-dollar program will cost them nothing.

Mr. Speaker, we all hear Speaker Pelosi say that she is the grandmother. Like Speaker Pelosi, I too am a mother and a grandmother. I can tell you that my constituents believe that this bill is bad for the middle class, bad for parents and grandparents and, even worse, for future generations.

I urge my colleagues to reject it as well so that we can work together truly on a bipartisan solution. The President’s own economic advisors have said that this bill will kill 5.5 million jobs. Americans back home are watching this and saying, What is Congress thinking? Why would they want to further sabotage our economy? This bill clearly is...
Instead of listening, Democrats squelched over 45 health care bills in favor of a tyrannical bill that cuts senior benefits, creates 118 new agencies, boards and programs, kills jobs and raises taxes by $730 billion. Unemployment is out of control, and the unemployment tax has skewed 26-year high and Speaker Pelosi’s health care bill will cost another 5.5 million jobs. Americans don’t want reform that comes with higher cost and unemployment.

This is a misguided effort by the majority, making it more complicated and expensive to create jobs. The Northern Kentucky Medical Society and thousands of doctors nationwide are opposed to this bill, H.R. 3962. They know that government takeover of health care will put bureaucrats between doctors and patients.

We can craft responsible health care legislation, and that’s exactly what my colleagues have done in H.R. 4038, the Common Sense Health Care Reform and Affordability Act. Our substitute reduces premium costs for every American to make health insurance more affordable and accessible, without raising taxes and without cutting Medicare benefits on our seniors.

Under our bill, insurance premiums are $5,000 cheaper per family than the cheapest Democratic bill. This bill takes waste and costs out of the system instead of adding to it. The Republican bill sheeds the pleas of the people without spending $1.3 trillion, without killing jobs and without hurting seniors.

Madam Speaker, H.R. 3962 is not re-form; it is tyranny. Give the people health reform, health freedom, and kill this bill.

Mr. RANGEL. Mr. Speaker, I yield 1½ minutes to my friend and leader from the great State of New York (Mr. CROWLEY).

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

Mr. CROWLEY. Mr. Speaker, I thank my good friend, the gentleman from New York, for yielding me this time.

I rise today in support of the Affordable Health Care for America Act, which will provide millions of hard-working American families the quality, affordable health care they deserve. In the past decade, the cost of health care for American families has skyrocketed. Premiums have doubled, yet wages remain stagnant at best. Last year, more than half of Americans postponed care or skipped their medications because they simply could not afford them. The status quo is no longer acceptable nor affordable, and the status quo is changing today. Today, I urge my colleagues to take action and deliver to the American people real change, a better, safer, more affordable way of life.

The Affordable Health Care for America Act will give American families peace of mind of mind that health care is not just a luxury for some but an affordable, accessible benefit for all of us.

I urge all of my colleagues to make history today and vote “yes” on this bill to make health insurance affordable and accessible for each and every American.

□ 1700

Mr. CAMP. Mr. Speaker, at this time I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Washington State (Mr. REICHERT).

Mr. REICHERT. I thank the gentleman for yielding.

Mr. Speaker, we have heard yesterday’s announcement eclipses 10 percent. Yet today we are considering a health care bill that will cost even more jobs and will raise taxes on families, on small businesses, on seniors, and takes away freedom.

This bill especially hurts our seniors, our greatest generation, by cutting their benefits, raising their premiums, and, on top of that, taxing wheelchairs, taxing pacemakers, taxing hearing aids.

This bill is not right for America, it is not right for families, it is not right for small businesses, and it is not right for seniors. We need real solutions.

Let’s focus on reducing the costs maybe, offer tax incentives, enact medical liability reform, allow people to buy insurance across State lines. These solutions bring lower costs and bring health care to those who really need it.

Mr. Speaker, the good news aspect, though, of this bill is that it takes away freedom, and this freedom came through great sacrifice, the sacrifice of men and women throughout the history of this great Nation so that we could choose and live a free life.

This bill takes away that freedom, the freedom to choose the health care that is right for you and your family. This bill takes away that freedom, requiring every American to purchase a government-approved health plan, pay a tax, or even go to jail. This bill takes away the freedom of patients to consult with their doctors without government interference. And then, it takes away that freedom, the freedom of our seniors to choose their own health care plan.

So, Mr. Speaker, this is not only a job-killing bill. Mr. Speaker, sad to say, this is a freedom-killing bill.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to the gentleman from New Jersey (Mr. PASCRELL), and thank him for the great job he has done for the country.

Mr. PASCRELL. Mr. Speaker, no one believes the loyal opposition that Democrats don’t care about seniors. Need I provide a history lesson 101 here?

Today is when we must ask ourselves the real reason we came to Congress. Was it to fulfill the hopes of the people, or to take the path of least resistance? The easy thing would be to say the problem is too big, the interests are too aligned, and then maintain the status quo. The hard thing is to bring everybody together, make the compromises that need to be made, and
give the American people true health care reform that will carry our country through for generations.

This is the same choice that was laid before the Members of the 89th Congress when they voted on the creation of Medicare and Medicaid. Do we want to be the generation that fails to make the changes necessary to our health care system? Would we be doing that now if we had been elected in 2009 and made the right choices in 2010? Would we be today as a nation had those Members simply succumbed to the difficulty of making real change? Where would we be today? Where would we be in mortuary? Where would we be with the seniors who were sick and poor at that time without those two programs?

We are now 40th among the industrial nations in infant mortality. When will we wait to have our consensus? We need this reform. Let us not leave another generation to wonder what we could have been.

Let's pass historic legislation that provides the promise of affordable health care for every American today and the generations to come.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Louisiana (Dr. Boustany).

Mr. Boustany. Mr. Speaker, today we will have a vote on a flawed, massive, and irresponsible health care takeover by government, pushed by Speaker Pelosi and House Democrats, that will cost more than $1 trillion. This bill will increase health care costs for seniors, increase taxes while Americans struggle to find work, and hurt seniors' quality care.

Mr. Speaker, as a heart surgeon, I saw the amazing innovation in my 20 years in practice in our system. In fact, in the early 1990s, an American surgeon, hopefully observing the death of a patient from blood clots to the lungs, was inspired and invented the first heart-lung machine that made open heart surgery possible. Many thousands of patients worldwide have benefited from this innovation, this innovation right here in the United States, innovation that will be stifled by the Pelosi health care bill.

There is another way. We can do better. House Republicans have solutions that will lower costs by creating real choice and competition. We will help those with preexisting conditions to get meaningful health care coverage, we will preserve U.S. leadership in medical research and education, and we will reduce frivolous lawsuits in medicine that needlessly drive up the costs for families.

As a heart surgeon, I know that we can achieve real health care reforms to bring down costs. But the Democrats' current bill will only lead to higher costs for millions of Americans and destroy what is currently working in our system.

There is a better way. There is a different way. There is a way to lower health care costs, help more people achieve a high quality doctor-patient relationship in this country and improve health care for all Americans.

Vote down this bill and support the Republican plan. Mr. Rangel. Mr. Speaker, I now yield 1½ minutes to the gentleman from Illinois (Mr. Davis).

Mr. Davis of Illinois. Mr. Speaker, passing this bill will move us closer to the realization that all men, women, and children in this country can have access to quality health care. It will reduce the waiting time in emergency rooms and shorten the length of time you have to wait to see a doctor. It makes it possible for people to have health insurance who have never had any before in their lifetime and to see a doctor on a regular basis. It recognizes the needs of people with disabilities. It seriously increases the number of community health centers, protects disproportionate share and teaching hospitals, and promotes health awareness and education. But, most importantly, it prolongs and enhances life, as well as its quality.

This is the most significant health legislation passed in this country since Medicare and Medicaid. Residents of my district have been calling all day asking that I vote for them, that I would vote for Illinois, that I would vote for them, yes, I will, because I believe that health care ought to be a right and not a privilege.

I wanted a single-payer system, but I will vote for H.R. 3962 because it is good for Illinois. It is good for me, it is good for you, and it is good for America.

Mr. Camp. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Nevada (Mr. Heller).

Mr. Heller. Mr. Speaker, I thank the ranking member for his exceptional hard work in producing a Republican alternative that does not raise taxes, raise premiums, increase our debt or increase health care costs. In a recent speech, Democratic leadership stated that getting votes today will be easier because Democrats want to go home.

Mr. Speaker, the Pelosi health care bill will cost Americans more than $5 million jobs. Despite national unemployment at 10.3 percent, and in my home state of Nevada, over 13 percent unemployment, we are moving forward with this bill. For the majority, this is fine, if Members of Congress get to go home.

This legislation raises billions in new taxes on small businesses and increases health care premiums by $15,000 per family on average. But, as I said, as long as the majority gets to go home, this doesn't matter.

This bill costs $500 billion from Medicare, affecting more than 20,000 seniors in my district and over 100,000 statewide, and also avoids meaningful medical liability reform. But the majority will support it, because they get to go home.

This bill's individual mandates will result in 9 million Americans paying a new tax or facing criminal penalties. These penalties include $250,000 fines and/or 5 years in jail for failure to pay the tax. However, this doesn't matter, as long as the majority gets to go home today.

Mr. Speaker, this bill lacks enforceable citizenship verification provisions. As many as 8.5 million illegal immigrants will be eligible for taxpayer-subsidized health care under this legislation. But, of course, if the majority gets to go home, it simply doesn't matter.

Yet the height of hypocrisy is that Members are not required to participate in this government-run health care program.

Unfortunately, the strategy to pass this massive bill hinges upon Members of Congress wanting to go home, instead of passing legislation that will help the American people.

Mr. Rangel. Mr. Speaker, I yield 90 seconds to a hardworking member of the Ways and Means Committee from the sovereign State of New York (Mr. Higgins).

Mr. Higgins. Mr. Speaker, the American health care industry is a $2.5 trillion industry. It represents 17 percent of the American economy, as measured by the gross domestic product. Yet our outcomes, according to the World Health Organization, are pathetically falling behind. We are 37th in overall quality. Unacceptable in America. We are 41st in infant mortality. That means in 40 other countries, from birth to 1 year of age, kids live by a higher percentage than they do in the United States. Unacceptable in America. We are dead last of any industrialized country in preventable deaths. Unacceptable in a good and generous Nation.

This is a uniquely American problem with a uniquely American solution. We look to not-for-profit plans, like the Cleveland Clinic, the Mayo Clinic and Johns Hopkins. They are early adapters of new innovation, and they are providing the highest quality health care not only in the Nation, but throughout the world, at the lowest possible cost. That is the health care that I want for my family, that is the health care that I want for my community, and that is the health care I want for my Nation.

We have been debating this issue not for seven months, but for seven decades. It is time for change. I understand that reform is tough. The reform that I have proposed has dynamics in all those who profit by the older order, and only lukewarm defenders in all those who would profit in the new order. On health care, most Americans are rooting for the reformer.
and you flipped on and only heard the majority party, you would think, wow, what a great plan. I mean, really, you would think people are just going to fall all over themselves, and all these adjectives and declarative statements just seem wonderful. Until you look inside that bill and you find handcuffs.

Now, I am not talking about figu- rate handcuffs. I am talking about criminal penalties; criminal penalties that have been mentioned by the gentle- man from Texas, criminal penalties that have been mentioned time and again on this floor. We have heard from the best and the brightest all after- noon, and not a one of them have an- swered why it is you have to crim- inalize people to coax them into a plan that is fabulous. It makes no sense.

And these aren’t my words. This is actually coming from the Joint Com- mittee on Taxation, in a letter that was written, ironically, with Chairman CHARLIE RANGEL as the chairman of that committee, released 48 hours ago, that says in fact if you don’t comply with the individual mandate, what hap- pens? You can be subject to 5 years in prison and you can be subject to a quarter of a million dollars in fines.

And the other side, with all due re- spect, with all the adjectives and all the flourishing speech, has failed to an- swer that question.

I submit to you, if we listen today, if we listen to the remainder of this de- bate, they will be silent in terms of a good answer as to why it is you need to criminalize people to coax them into a plan. It’s a failure, and we ought not stand for it.

The small businesses, the entre- preneurs, and the self-employed that this would have an impact on, they say, “Look, don’t criminalize us. Give us relief. Let us purchase across State lines.” Not in the Democrats’ bill. “Give us real tort reform, real liability reform.” Not in the Democrat bill in any substantive way. “Let us purchase and work together to pool to lower any substantive way. ‘Let us purchase across State lines.’ Not in the Democrat bill in any substantive way.

Mr. RANGEL. At this time, I yield 90 seconds to the gentleman from Ken- tucky (Mr. YARMUTH).

Mr. YARMUTH. Mr. Speaker, 3 years ago today, the citizens of Louisville, Kentucky, sent me to this body. They sent me here largely to help bring us to this moment. I was sent by a recent college graduate who had to give up her coverage under her parents’ health insurance policy and couldn’t get her own cov- erage to cover her lifelong allergic con- dition.

I was sent by the family of a 10-year-old little boy who wrote me, begging for help to help pay for the $50,000 they have to pay annually to care for their autistic son.

I was sent by the Louisville woman whose insurance was dropped in the middle of her cancer treatment.

I was sent by thousands of seniors, struggling to pay their prescription drug costs.

I was sent by people like the local re- altor who is trying to figure out right now how to pay his next year’s insur- ance bill he just received with a 32 per- cent increase.

Today is the day those Americans get the help they have been praying for. It is the day we take a giant step toward Union that we all seek. I am very proud to be a part of this historic day, and I am also very proud for the all-too-patient citizens of America who sent me here, along with many of my colleagues, in 2006 to cast votes for the Affordable Health Care for Americans Act.

Mr. CAMP. Mr. Speaker, at this time, I yield 1 minute to the gentlewoman from Michigan (Mrs. MILLER).

Mrs. MILLER of Michigan. Mr. Speaker, during the past year, the Democratic majority has passed so many bills that have done absolutely nothing to help our economy. Instead, they’ve raised taxes, they’ve exploded the deficit, and they actually have killed off jobs. Then, yesterday, the national unemployment rate went up past 10 percent—actually, to 10.2 per- cent, with no end in sight.

So it is incredible that today this House may pass a job-killing, tax-hik- ing, deficit-exploding government takeover of our health care. And one of the most disingenuous things that has been said is that if you like your current health care, that you can keep it. Well, not so fast.

In my county, Macomb County, Michigan, the Chamber of Commerce just did a survey of all of their mem- bers. They asked them that if, rather than continuing to provide good health care plans for their employees, they would instead take the 8 percent pen- alty that is included in this bill, and guess what? No surprise. The over- whelming majority said they would of course dump their employees out into the public plan.

Mr. Speaker, we are going to have a complete government takeover of our health care system faster than you can say, “This is making me sick.” Vote “no.”

The SPEAKER pro tempore. The gen- tleman from Michigan has 8 minutes remaining. The gentleman from New York has 14½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I would like to yield 1 minute to the Congress- woman from California (Ms. LEE), who is the chairperson of the Congressional Black Caucus and has done such a great job on the question of diversity as well as other parts of the bill for women.

Ms. LEE of California. Mr. Speaker, on behalf of the Congressional Black Caucus, I rise in strong support of this bill. Known historically as the con- science of the Congress, we recognize that it is our moral responsibility to pass this today.

I want to thank the gentleman and commend him and the other Chairs of the tri-committees as well as our lead- ership and our Speaker for bringing us to this point today.

The strong public option in this bill will provide our constituents with the choice and competition they want. It will help improve our health care and help eliminate health disparities, and this bill recognizes that an ounce of prevention is worth a pound of cure. It will help people who choose to keep their private plans by limiting annual rate increases by insurance companies. It is the best, so far, of this year’s historic vote is another step forward in our quest for social justice. It really is about life and death, but it’s not the end of the process. The Congressional Black Caucus will keep fighting until a final bill is on the President’s desk.

Today, finally, health care will be- come a basic human right for all, ra- ther than a privilege for the few. We all have been called today for such as this. Let us rise to the occasion and vote yes, affordable health care for all.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentlewoman from Oklahoma (Ms. FALLIN).

Ms. FALLIN. Mr. Speaker, the Amer- ican people understand the need for health care reform. We don’t want socialized medicine. They don’t want the Federal Government taking over our health care decisions, taking away our freedoms of choice about health care. They don’t want more Federal deficit spending on the backs of our children and future generations of our children, and they don’t want more taxes upon small business, espe- cially in this recession.

They don’t like the Federal Govern- ment taking away our freedoms guar- anteed under this Constitution, and they don’t want the Federal Govern- ment interfering in our States’ rights. They don’t want unfunded mandates upon the States, and they don’t want government-funded taxpayer abortions upon our families.

Mr. Speaker, men and women have fought for our freedoms for this Nation for generations, but this health care bill will change the face of our Nation and put our Nation on a trajectory of a Federal Government takeover in so many areas of our freedoms and our lives.

Let’s reject this health care bill, and let’s start all over and pass real, mean- ingful health care reform.

Mr. RANGEL. I yield 1 minute to the gentlewoman from New York, Congresswoman VELÁZQUEZ.

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

Ms. VELÁZQUEZ. For too long, mil- lions of Americans have suffered with- out access to the medical treatment they need. Right now, as we debate this measure, too many Americans are wor- rying about how they will find health care coverage if they lose their jobs. On this day alone, 14,000 Americans will lose their coverage, and millions of other citizens, including one in every
three Hispanics, lack health insurance coverage.

Today all of that changes. This is the moment. No longer will insurance companies abandon Americans when they most need help. This bill will end the practice of preexisting condition coverage because of preexisting conditions. The 36 million uninsured Americans will finally have coverage. Choice, competition, and transparency will be brought to the insurance market, meaning better care at lowered costs. I say this to my colleagues: It has been too long. Let us pass this bill.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. Crenshaw).

Mr. CRENshaw. Mr. Speaker, a lot of the men and women that I represent in northeast Florida are members of the military, and we've been working for 15 years to make sure they have adequate healthcare. They deserve it. They defend us every day.

They asked me, How is this new Democratic plan going to affect my TRICARE and my TRICARE for life? The government really wants what this slippery slope with the public option is going to do to existing coverage. If you take this Democratic plan, you will see it's complicated, 2,000 pages long. It's unproven. It's untested. It's filled with uncertainty.

At the end of the day, this Democratic plan is a dangerous experiment on the backs of the American people without their consent. If this were the medical field, that would be unethical. It would be malpractice. There is a better way, Mr. Speaker. There is a better way.

Mr. RANGEL. I yield 1 minute to the gentleman from West Virginia (Mrs. Capito).

Mrs. CAPITO. Mr. Speaker, I rise today to voice the concerns of my constituents who believe the Speaker's trillion-dollar 1,990-page bill is simply the wrong solution for West Virginia's families. We were told that under the President's plans, those who like their health care would be able to keep it. Well, tell that to the 72,000 West Virginians on Medicare Advantage who will see the program slashed by $170 billion under this plan.

Consider one of my elderly constituents from Dunbar, West Virginia, who called me about the enhanced benefits of Medicare Advantage to cover her rheumatoid arthritis and her diabetes. She suffered a stroke, a brain aneurism, and she is on more than a dozen prescriptions. She relies on these services, and she fears that this bill will put them at risk. Sadly, she is right, because this bill will change her health care.

Mr. Speaker, we need health care reform, but we can do better than this. The SPEAKER. The gentleman from Michigan has 5 minutes remaining. The gentleman from New York has 11/2 minutes remaining.

Mr. RANGEL. Thank you. I yield 1 minute of that to the gentleman from the great State of New York, Gregory Meeks.

Mr. MEEKS of New York. The camera of history is rolling, and I am so happy to play a part in it, because just as we created history in the thirties with Social Security and in the sixties with Medicare, we will create history tonight in passing H.R. 3962.

Dr. King once asked the question, How long? Well, because of H.R. 3962, how long before all Americans have access to affordable and quality health care? Not long. How long before we end discrimination for preexisting conditions? Not long. How long before we ensure that no Americans fear bankruptcy or financial ruin due to illness? Not long. How close we get to the doughnut hole, helping all of our senior citizens? Not long. How long before we begin to control the escalating prices of insurance and health care? Not long. How long before all Americans, all of us, can have access to quality health care? Not long.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. Goodlatte).

Mr. GOODLATTE. Mr. Speaker, what's in the 2,000-page monstrosity that's costing the taxpayers over $1 trillion in costs? Well, we're going to see tax increases of $800 billion, and $500 billion in cuts from Medicare.

Well, take a look on page 94. Section 202(c) prohibits the sale of private health insurance policies beginning in 2013, forcing individuals to purchase coverage through the Federal Government.

On page 225, however, section 330 permits, but does not require, Members of Congress to enroll in government-run health care.

Page 122, section 233(a)(3) requires the commissioner, a new health insurance czar, to issue guidance on best practices of plain language writing. This from the same people who wrote this 2,000-page health care bill.

Page 183, section 305(a) gives the commissioner the power to enlist appropriate entities, like Planned Parenthood and ACORN, to engage in outreach to specific vulnerable populations about the bill's new programs.

Oppose this bill.

Mr. RANGEL. Mr. Speaker, at this time, I yield 1 minute to Congressman Conyers, the distinguished dean of the Congressional Black Caucus, senior Member of this great House of Representatives, and someone that had indicated his concern about health care for many, many years ago.

Mr. CONYERS. Thank you, Chairman Rangel, and all of our colleagues that have supported single-payer health care. Eighty-six other Members are now working to make sure that we get this bill passed. I single out my colleagues Dennis Kucinich and Anthony Weiner for their particularly effective work.

But I want to say that this is the same battle that some people went through when we passed Social Security. We had the same naysayers. The same people when we passed Medicare, the same naysayers. The same people when we passed Medicaid, the same naysayers. And now we try to reform health care today, and what do we get? The same people saying "no" again.

So I'm proud to lend all of the support that I can to make sure that this bill becomes law, that more people are covered, and that preexisting conditions no longer will be an excuse to get rid of people.

Mr. CAMP. Madam Speaker, at this time I yield 1 minute to the gentleman from Georgia (Mr. Kingston).

Mr. KINGSTON. Thank you. Madam Speaker, what we have today is another Pelosi plan for America. But let's remember the Pelosi plan for jobs: an $800 billion stimulus plan that caused unemployment to go from 8.5 percent to over 10 percent.

Let's remember the Pelosi plan for automobiles: Cash for Clunkers, a $3 billion program that even the Democrats agreed did not work and was killed after 3 weeks.

The Pelosi plan for fiscal discipline: a $1.4 trillion dollar debt this year, the highest in history.

And let's not forget the Pelosi plan for national security: dithering in Afghanistan.

Now we have the Pelosi plan for health care: it kills small businesses and jobs. It raises taxes. It raises premiums. It cuts Medicare. It takes away your current health care coverage and spends $1 trillion.

Let's consider the Pelosi plan for a government takeover of health care and join the bipartisan Members of this Congress who plan to promote an alternative which is far better.
Mr. RANGEL. Madam Speaker, I yield for the purpose of making a unanimous consent request to Mr. FALEOMAVAEGA, my friend from Samoa. (Mr. FALEOMAVAEGA asked and was given permission to revise and extend his remarks.)

Mr. FALEOMAVAEGA. Madam Speaker, God is good. I rise in full support of the health care needs of all our fellow Americans. God bless America.

Madam Speaker, I rise in strong support of H.R. 3962, legislation to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes. This bill will control rising medical costs and also extend health care coverage to uninsured American citizens throughout the United States and its Territories.

I want to thank Speaker NANCY PELOSI for her leadership and my colleagues in Congress for their support on this important bill. Especially, I extend my gratitude to the Chairman of the House Committee on Energy and Commerce, Congressman HENRY WAXMAN; and the House Committee on Ways and Means, Congressman CHARLES RANGEL for listening to the concerns of the Territories and for their willingness to work with the Territorial delegates on resolving their concerns.

I also want to commend my fellow Territorial delegates for their hard work and efforts, in working hand-in-hand to reduce health disparity facing the Territories. I especially want to recognize Congresswoman DONNA CHRISTENSEN for her work in the House Committee on Education and Labor and to Congresswoman MADELEINE BORDALLO for her leadership as the Chairwoman of the Congressional Asian Pacific American Caucus Healthcare Task Force.

Madam Speaker, the Affordable Health Care for America Act, or H.R. 3962, will improve health care for Americans living in the insular areas. Under the provisions of this legislation, from FY2013 to FY2019, American Samoa will receive additional Medicaid funding in the amount of $239.5 million. Moreover, its Federal Medical Assistance Percentage (FMAP) will be raised to the highest FMAP applicable to any of the 50 States and District of Columbia. As a result American Samoa will assume an FMAP no less than 75 percent, the FMAP for Mississippi which has the highest among the 50 States.

American Samoa will also work together with the Secretary of Health and Human Services to ensure the Territories’ parity by 2020. And to make this transition, the Secretary will also assist to make appropriate modifications to the Territory’s existing Medicaid programs. This will require comprehensive assessment of the existing Medicaid program and health care services in American Samoa.

I am pleased that American Samoa and the insular areas will have the opportunity to become part of the Exchange program, the centerpiece of the Health Care Reform legislation. Again, thank my Territorial delegates for their hard work to ensure that Congress continues to recognize the need and unique set of circumstances we have in the Territories. To help carry out the Exchange program, $300 million is to be allocated among American Samoa, the CNMI, Guam, and the USVI, based on consultation with the Secretary of Health and Human Services. If American Samoa or any Territorial government chooses not to join the Exchange, its allocation will be added instead to that Territory’s Medicaid funding.

Madam Speaker, H.R. 3962 will bring much needed improvement to the health care system in American Samoa. The fact of the matter is rising medical costs and limited health care coverage where American Samoa’s remote location and exponential rate of chronic diseases, have led to a high number of people in the Territory with minimal or no access to quality health services. Indeed, findings from the American Samoa Health Survey completed in 2005 of 25 percent of the population have insurance. Subsequently, there is a tremendous need to address these concerns in a viable health care policy for the Territory.

For this reason, in a letter sent June 22, 2009, I wrote members of the Fono (American Samoa Legislature) to address the need to improve the health care system in the Territory. I specifically requested that the Fono should take advantage of the report from the Government Accountability Office for American Samoa (GAO) project, which includes policy recommendations on ways to improve the Territory’s health care system.

I commend the American Samoa Government especially the Office of the Lieutenant Governor and staff for their dedication and commitment to the CAAS project that was completed in 2007. I also want to commend the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) for committing federal funding from 2004 to 2007 to complete the CAAS project. My hope is for the American Samoa Government to follow through on the policy recommendations in the CAAS report and adopt the framework for health care reform that is now in place and supported by H.R. 3962. The Affordable Health Care for America Act, H.R. 3962, carries with it our expectations and hopes for quality and affordable health care for our people and with it a commitment; a commitment by every American is provided quality health care that they are entitled to and to receive health services that they so critically need.

I urge my friends and colleagues to support H.R. 3962 and pass this historical health care reform legislation.

Mr. RANGEL. I yield myself 2 minutes.

This is it for the members on the Ways and Means Committee and others that have demonstrated such outstanding leadership to be a part of history.

It’s unfortunate that we were unable to create an atmosphere of bipartisanship because, certainly, the 40 million people, all of our congressional districts, that had no insurance at all.

I am more than certain that my colleagues on the other side of the aisle have heard the very same stories we have; people who thought they were insured and they were not; people who wanted insurance and they would not insure them because they had some condition; other people who worked hard every day of their lives, but were not given insurance and they can’t afford to buy it.

No, this isn’t the Pelosi plan. This is a plan for all America, a plan to make us proud to know that our country is concerned about us and our children and our grandchildren. And, yes, the American Medical Association, AARP, and everyone is throwing papers around. But these are the groups, the national groups, that have asked America and this Congress to step up and fulfill our responsibility.

And it’s not just for our constituents. It’s for our great country, to have her as strong as she can be, to be able to know that we can compete with any other nation no matter what part of the world that we’re in; and that our workforce will not only be educated and talented in order to compete, but we will be healthy.

Every industrialized country takes care of their people. It’s not a political thing. Certainly being a Republican or Democratic thing. It’s: Are we going to be healthy? Are we going to be strong? Are we going to be certain that when you count America, count her among the healthy.

Madam Speaker, I want to bring to the floor an outstanding Member of Congress who is the subcommittee Chair on the Education and Labor Committee. As you know, three committees had jurisdiction and Education and Labor had jurisdiction. We had three chairs. But we had one subcommittee chairman who has just been outstanding. He’s been a friend of those without insurance, a friend of those who look forward to this bill’s being passed.

So it is with great distinction that I yield the balance of my time to Mr. ROBERT ANDREWS from New Jersey, and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore (Ms. EDWARDS of Maryland). Without objection, the gentleman from New Jersey will control the balance of the time.

There was no objection.

Mr. CAMP. Madam Speaker, at this time I yield 1 minute to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Madam Speaker, this is well intended. But you read section 501, and it basically says if you make too much to get free health care but you make too little to be able to buy it, you’re going to get taxed under this bill. It means well. But it does damage.

For those who have paid into Medicare for 40 years or so, who expected to have it, they get cut hundreds of billions of dollars, but illegals are going to be covered. Congress.

In the 1960s they meant well with the Great Society, but they offered a check for every child a woman could have out
of wedlock. Meaning well, wanting to help them, but they lured them into a rut with no way out, and they came to my court to be sentenced.

We hurt people when we do the wrong things. For the Declaration of Independence to pledge our lives, their fortunes, their sacred honor. This is a ‘declaration of dependence’ that pledges Americans’ lives, Americans’ fortunes, and there is no honor in that.

Mr. ANDREWS. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, the people of the country and Members of the House deserve a vigorous debate. They also deserve an accurate record. And I think the time has come to begin to clarify and correct some of the series of assertions that have been made here that are simply not correct.

There was an assertion made from the minority side a few minutes ago that the bill that has been specifically targeted at those who are on TRICARE or veterans health benefits. The gentleman may not know, but we do. Nothing will change for a person under TRICARE or veterans benefits if they do not wish to have that change at all.

There was a statement made on the other side that the bill will “cover illegal aliens.” That is incorrect. There is no subsidy and there is no coverage for an undocumented person.

There have been numerous statements made on the other side that there will be massive tax increases on the American people. Here is the fact: the fact is that there is a surtax in this bill that helps to pay for coverage of uninsured people and for better quality care. It affects the top 0.3 percent of households in this country. If you’re an individual and you make more than $500,000 a year adjusted gross income, if you’re a couple and you make more than $1 million a year adjusted gross income, it affects you.

The statement has been made repeatedly the bill will add to the deficit. That’s not the truth. That’s not what the Congressional Budget Office says. They say the contrary. They say that the net effect of this bill is it will reduce the deficit in the first 10 years by in excess of $100 billion and that in the second 10 years, the bill will reduce the deficit by somewhere in the neighborhood of one-quarter of 1 percent of GDP.

The statement has been repeatedly made that it is a crime not to have health insurance. Here’s the accurate statement: because there is a penalty imposed on individuals who don’t meet the individual mandate, and, by the way, that individual mandate has within it very generous subsidies and it has a hardship exemption, but it has been said it is a crime not to have health care. That is not accurate. It is a crime to willfully and intentionally evade taxation, just as it is with every other tax.

It has been said this is a government takeover of health care. That is false. This is a consumer takeover of health care. And those who would be apologists for the insurance industry don’t like that. The American people do and will.

Madam Speaker, I reserve the balance of my time.

Mr. CAMP. Madam Speaker, at this time I will place in the RECORD a letter from the Joint Committee on Taxation, which on page 3 indicates that both misdemeanor and felony penalties with imprisonment of up to 5 years will be imposed.

CONGRESS OF THE UNITED STATES, Joint Committee on Taxation, Washington, DC, November 5, 2009.

Hon. Dave Camp, Chair, House of Representatives, Washington, DC.

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

TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH INSURANCE

H.R. 3962 provides that an individual (or a husband and wife in the case of a joint return) who does not, at any time during the taxable year, maintain acceptable health insurance coverage for himself or herself and each of his or her qualifying children is subject to an additional tax. The tax is equal to the lesser of (a) the national average premium for single or family coverage as applicable, as determined by the Secretary of Treasury in coordination with the Health Choices Commissioner, or (b) 2.5 percent of the excess of the taxpayer’s modified adjusted gross income over the threshold amount of income required for the income tax return filing for that taxpayer. This tax is in addition to both regular income tax and the alternative minimum tax, and is prorated for periods in which the failure exists only for part of the year. In general, the additional tax applies only to United States citizens and resident aliens. The additional tax does not apply to those who are residents of possessions or who are dependents of persons who do apply to those whose liability in coverage are de minimis or those with religious conscience exemptions. The additional tax does not apply if the maintenance of acceptable coverage is impossible for the individual or if the person’s income is below the threshold for filing a Federal income tax return.

RANGE OF CIVIL AND CRIMINAL PENALTIES FOR NONCOMPLIANCE

You asked that I discuss the situation in which the taxpayer has chosen not to comply with the mandate. The Code provides for both civil and criminal penalties to ensure complete and accurate reporting of tax liability and to discourage fraudulent attempts to defeat or evade tax. Civil and criminal penalties are applied separately. Thus, a taxpayer convicted of a criminal tax offense may be subject to both criminal and civil penalties, and a taxpayer acquitted of a criminal tax offense may nonetheless be subject to civil tax penalties. In cases involving both criminal and civil penalties, the IRS generally does not pursue both simultaneously, but delays pursuit of civil penalties until the criminal proceedings have concluded.

The majority of delinquent taxes and penalties are collected through the civil process.

In determining whether a penalty applies along with an adjustment to a tax return, the examining agent is constrained not only by the applicable statutory provisions, but also by the written policy of the IRS not to treat penalties as bargaining points but instead to develop the facts sufficiently to support the decision to assert or not to assert a penalty. The goal is predictability, fairness and predictability in administration of penalties.

If the government determines that the taxpayer or tax return is the result of willful behavior, the following penalties could apply.

CIVIL PENALTIES

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

Section 6663—a fraud penalty of 75 percent of the underpayment, if the government can prove fraudulent intent to avoid taxes by clear and convincing evidence.

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

Section 6651—delinquency penalty of .5 percent of the underpayment, each month, up to a maximum of 25 percent of the underpayment.

CRIMINAL PENALTIES

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

Section 7203—misdemeanor willful failure to pay is punishable by a fine of up to $25,000 and/or imprisonment of up to one year.

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

APPLICATION OF PENALTIES UNDER CURRENT RULES

The IRS attempts to collect most unpaid liabilities through the civil procedures described above. A number of factors distinguish civil from criminal liabilities, in addition to the potential for incarceration if found guilty of a crime. Unlike the standard in civil cases, successful criminal prosecution requires that the government bear the burden of proof beyond a reasonable doubt of all elements of the offense. Most criminal offenses require proof that the offense was willful, which is a degree of culpability greater than that required in a civil penalty cases. For example, for a prosecution for willful failure to pay under section 7203 requires proof that the taxpayer intentionally violated a known legal duty and that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty applies unless the taxpayer can establish reasonable cause and lack of willful neglect with respect to his failure to pay.

Criminal prosecution is not authorized without careful review by both the IRS and the Department of Justice. In practice the application of criminal penalties is infrequent. In fiscal year 2008 the total cases referred for prosecution of legal source tax crimes were as follows. Investigations initiated—1,531. Indictments and informations—757. Convictions—666.
November 7, 2009

CONGRESSIONAL RECORD—HOUSE
H12865

Sentenced—445.
Incarcerated—498.
Percentage of those sentenced who were incarcer-ated—71.2.
Of the 666 convictions reported above for fiscal year 2008, fewer than 100 were convictions for willful failure to file or pay taxes under section 7203. Civil penalties outstanding on convictions imposed. For example, in fiscal year 2008, compared to the 666 convictions, approximately 392,000 accuracy related penalties were assessed on individual returns. Also in fiscal year 2008, the IRS assessed 5,502 penalties under section 6672 for frivolous positions taken on returns.

I hope this information is helpful for you. If I can do further assistance, please contact me.

Sincerely,

THOMAS A. BARTHOLOM.W.
Madam Speaker, at this time I yield 1 minute to the gentleman from Texas (Mr. POE). Mr. POE of Texas. Madam Speaker, in my prior life I was a judge for 22 years. I tried only criminal cases. There is no way to make everyone that was to buy insurance whether they want to or not. If they don’t, they’re taxed. But that tax is really a fine. Be that as it may, if they don’t pay the fine, they’re in violation of the IRS Code and they can pay another $250,000 fine and go to a Federal prison for 5 years.

That is government oppression of the people, forcing them to buy insurance whether they want to or not. That is repressive government control, and that’s the way that I see it. If they don’t submit, they are forced to go to jail.

You know, this bill is about government control. It’s not about choice. It’s oppression. It’s not about liberty. The Constitution starts out with “We the people.” If this bill passes, especially that section, let’s scratch out “We the people” and write in the phrase “We the subjects of Big Government.”

And that’s just the way it is.

Mr. ANDREWS, Madam Speaker. I’m pleased at this time to yield 1¼ minutes to the gentlewoman from Ohio (Ms. FUDGE), who’s one of the authors of the small business provisions in the bill.

Ms. FUDGE. There comes a time, Madam Speaker, when we must choose that which benefits the greater good or look for selfish reasons to support the status quo. Now is that time and I choose the greater good.

When I go home, Madam Speaker, I will be able to say that I was asked to make health care more affordable and I said “yes.” This bill makes health care affordable for 36 million more Americans by ensuring that working-class citizens will never have to pay more than 12 percent of their income on health care premiums and that people whose incomes are 400 percent of poverty or less will receive their premiums in the form of subsidies. More than 163,000 households in my district alone will benefit from these subsidies.

When I go home, Madam Speaker, I will be able to say: “I was asked to help the laid-off worker, the small business owner, the working poor, and those who can’t make ends meet in this very struggling economy, I said ‘yes.’” When asked to ensure that those who have health care today but may be dropped tomorrow are taken care of, I said “yes.” When asked to exhibit the courage needed to fight for change, I said “yes.”

When the history of the 111th Congress is written, I choose to be in that number that said “yes” to the people of America.

Mr. CAMP. Madam Speaker, I yield 1 minute to the gentlewoman from California (Ms. ROHRABACHER). Mr. ROHRABACHER. Madam Speaker, this attempt at sliding Americans into dependence on a government-controlled health care system will cost hundreds of billions of dollars more, including billions to provide health care for illegal aliens while at the same time cutting Medicare by hundreds of billions of dollars.

This reform will destroy the freedom of the American people to make health decisions with their doctor and the doctor of their choice. It will transform our system rather than reform it, and what we will end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

Mr. ANDREWS. Madam Speaker, nurses make a great contribution to our health care system, and a gentle-woman who is a nurse has made a great contribution to this bill. I yield 2 minutes to the gentlewoman from New York (Mrs. McCARTHY). Mrs. McCARTHY of New York. I thank my colleagues, Mr. ANDREWS, and I also thank GEORGE MILLER for also working with us.

We have known for years that we have a shortage of doctors, especially primary care doctors, and we have had a shortage of nurses. This bill is going to help that.

You know, when we talk and I hear some of the charges coming from the other side, I am wondering where have I been all of these months when I sat through the committee hearings and heard what we are doing.

I want to say with the Education and Labor Committee, the Nurse Training and Retention Act and the High-Teen Nurse to- School Nurse Ratio Improvement Act is in this bill, H.R. 3962. The Nurse Training and Retention Act will provide grants so we can have more new nurses, but to have more new nurses, we have to have those who are educated and to teach those nurses. We have that in this bill, too.

I also want to say that for years I have been fighting with the insurance companies to make sure that children who are born with disfigurements on their face can have corrections so long term they won’t have those scars, physically and mentally, and to help those families adjust to the child. In this bill, we will be able to say that the plastic surgeons can work on these children.

Think about a child who is born without an ear. The insurance companies say that is cosmetic. That is not cosmetic. The ear is actually part of the body so you can actually hear better. The emotional scars that happen to the children that are born with these deformities, that is wrong.

If we can’t take care of our children in this country, if we can’t make sure our seniors on Medicare get the kind of care that they need—I will tell you, I just went through surgery. I went to get my prescriptions filled, and my pharmacist said to me, How lucky, you don’t have to pay anymore for your prescriptions until January 1. Why? Because I have coverage, because I have health care from the Federal Government. We can do better, and we should.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Minnesota (Mr. KLINE) for 40 minutes.

Mr. KLINE of Minnesota. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, we have before us today more than 2,000 pages of legisla-tive text that will give us public policy that costs more than $1 trillion and creates a huge morass of government bureaucracies. Over a hundred new offices, bureaus, commissions, and programs. Let’s look briefly at just one of these new offices.

The Democrats empower a new super bureaucrat with unprecedented authority over personal health care decisions, the health choices commissioner, heading up the Orwellian health choices administr-a-ration.

In the short time we have had since this legislation was made public, we have come through these pages—in the first part of these 2,000 pages—to see if we could get a picture of the responsibilities, authorities, and powers that were given to this individual. As you can see, Madam Speaker, we actually had to go back to the supply store to get enough of these tabs.
Madam Speaker, our health care system is the envy of much of the world. That does not mean it is perfect.

Major challenges such as pre-existing conditions and portability can be dealt with by breaking down barriers between states and through nationwide underwriting. California-style liability reform provides a model to reduce the cost of defensive medicine and can significantly reduce the cost of health care.

Tax incentives can be used to encourage broader participation by families, without federal mandates.

The Speaker and her congressional advisors are committed to government-run health care. We can solve existing problems without adding a trillion dollars on the backs of average American taxpayers.

Vote “no” H.R. 3962. Help save us from single payer healthcare.

Mr. KLINE of Minnesota. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey has 1½ minutes remaining.

Mr. ANDREWS. Madam Speaker, at this time I would like to yield to a gentleman who authored a very key provision about saving money through medical records technology, the gentleman from Oregon (Mr. Wu) for 1½ minutes.

Mr. WU. Madam Speaker, I rise today in strong support of health insurance reform. In 20, 40, 60 years, this legislation will stand beside Social Security, the GI bill, and Medicare as a pillar of American health care and humane values.

We need a new health insurance exchange or marketplace to expand access and provide people with a menu of quality health insurance options so they can choose the plan that best meets their own needs. Tax incentives can be used to encourage broader participation by families, without federal mandates.

The Speaker and her congressional advisors are committed to government-run health care. We can solve existing problems without adding a trillion dollars on the backs of average American taxpayers.

Vote “no” H.R. 3962. Help save us from single payer healthcare.

Mr. KLINE of Minnesota. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey has 1½ minutes remaining.

Mr. ANDREWS. Madam Speaker, at this time it is my honor to yield 4 minutes to a person who has spent a distinguished career in this House fighting for this issue. The principal authors of this bill, the leader of our committee, the chairman of the Committee on Education and Labor, the gentleman from California (Mr. GEORGE MILLER).

Mr. GEORGE MILLER of California. Madam Speaker, I thank the gentleman so much for his contribution to this legislation, to the debate in this House, and to the role he has played in informing our Members and the public about this bill.

I want to begin by giving thanks. Madam Speaker, particularly on my committee, I want to thank the staff that have worked so terribly hard, Michele Varnhagen, Megan O’Reilly, Jody Coleman, Annon Albright, Meredith Regina, and Rachel Racusen, who have all supported this tremendous team and the professional staff of the Committees on Ways and Means and Energy and Commerce, and certainly to my colleagues, Chairman Rangel and Chairman Waxman, and to our subcommittee chairmen, Mr. ANDREWS, Mr. PALLONE and Mr. STARK. It has truly been an honor to have been involved in this debate and sit in the same room with the dean of our House, Mr. Dingell. I had to be able to craft this legislation. It is an honor I will remember the rest of my life, and I thank the Democratic leadership for giving us the space to bring President Obama’s bill to this House so we can pass it and change America. And I want to thank Speaker Pelosi. Without her leadership, her tenacity and her passion, we would simply not be here today.

We are about to make history, and we are about to make history. The Speaker and her congressional advisors are committed to government-run health care. We can solve existing problems without adding a trillion dollars on the backs of average American taxpayers.

Vote “no” H.R. 3962. Help save us from single payer healthcare.

Mr. KLINE of Minnesota. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey has expired.

Mr. KLINE of Minnesota. Madam Speaker, I rise for the purpose of a unanimous consent request to the gentleman from California (Mr. Lewis).

Mr. LEWIS of California asked and was given permission to revise and extend his remarks.

Mr. LEWIS of California. Madam Speaker, I rise to oppose H.R. 3962.
But in America today, because of the absence of this policy, because of the absence of a comprehensive health care bill that provides universal access, because of the failure of a bill that will help families that are struggling to meet their bills and pay the premiums, because of the failure, as The Wall Street Journal said, we pay a huge price in innovation because people know they will be penalized if they start a new business, if they take an idea and try to take it to fruition, if they switch jobs for a better opportunity maybe career-wise but that doesn’t have insurance, if they want to go to work for a start-up where they can’t provide insurance.

Let’s give America for the first time health care security for their families, their friends, their kids, and their neighbors.

Madam Speaker, I rise in support of this historic legislation to fix our broken health insurance system and finally bring affordable health coverage to every American.

We are truly on the verge of making history. Never before has the House or Senate approved a bill to guarantee every American access to affordable health care.

Never before.

Not that we haven’t tried.

The fight to reform this Nation’s health care system has spanned nearly 100 years, across generations and many great leaders, from Teddy Roosevelt to Franklin Roosevelt to John F. Kennedy to President Clinton to my own personal hero, Ted Kennedy.

But time and again these efforts were stymied by special interests.

The need for reform is dire.

Hundreds of thousands of people are losing insurance each month.

At least 36 million Americans have no coverage at all—including nearly 50,000 people in my district in Northern California.

Over half of all personal bankruptcies are due to a medical incident.

Businesses are choking on bloated health care costs.

Innovation is being stifled. Our competitiveness is undermined.

But this year is different. This time is different.

The American people literally cannot afford to wait any longer, and today we will cast a history-making vote to guarantee all Americans access to quality, affordable health insurance.

We must not fail again.

An unprecedented effort by the House led us to this milestone.

Three committees and our diverse Caucus worked together in an extensive and coordinated fashion, with one purpose—to fulfill a decades-old and yet still urgent promise.

We engaged the public in one of the most transparent debates of federal legislation in history, including over 2,000 events across the U.S. since July alone.

The result is a bill that reflects what we have heard from workers and families, from small business owners and economists, from seniors and college students, from doctors and nurses.

The Affordable Health Care for America Act will directly meet the needs of Americans and the goals that President Obama set for reform:

It lowers costs for families and businesses, Protects people’s choices of doctors and health plans, reduces the deficit, and Ensures access to quality, affordable health insurance for all Americans.

For the first time in U.S. history, all uninsured Americans will be able to purchase quality, affordable coverage through a new Health Insurance Exchange, where they will be able to choose from a menu of options: a public health insurance option or several private plans.

And for those that already have insurance, our bill will grant them the security of knowing that their coverage will always be there.

Never again will Americans worry about losing their health care if they change or lose their job.

Never again will someone be denied health care coverage because of a pre-existing condition.

Never again will a patient have to worry about their insurance company rescinding their policy when they need coverage the most.

Never again will a small business owner have to worry about unpredictable and unaffordable premiums.

Our bill, H.R. 3962, will end the many injustices that workers, families, and businesses face in today’s system.

It will finally make health insurance work for consumers—not insurance CEOs.

Let me be specific about what our reforms will mean for the American people:

No more co-pays or deductibles for preventative care;

No more rates increases because of a pre-existing condition, gender, or occupation;

An annual cap on out-of-pocket expenses; Guaranteed affordable dental, hearing and vision care for children;

Lower prescription drug costs for seniors;

Young people will be able to stay on their parents’ insurance through their 27th birthday; and

A ban on lifetime caps on what insurance companies will pay, so patients will never again be one treatment away from medical bankruptcy.

As I mentioned earlier, this legislation meets our commitment to fiscal responsibility.

Every penny of this bill is fully paid for through a combination of revenue raised by placing a surcharge on the wealthiest Americans and savings generated by making Medicare and Medicaid more efficient.

These reforms will strengthen Medicare for seniors and shift our system’s focus from quantity of health procedures to quality of care and producing healthier outcomes for patients.

The Congressional Budget Office reports that our bill will reduce the deficit by more than $100 billion over the next decade and stabilize the growth of health spending, leading 11 chief health care economists to declare our legislation “vital to the Nation’s fiscal and economic future.”

As with previous efforts to reform health care, this bill received an enormous amount of public scrutiny.

In the last few months, opponents of health reform have conjured up every falsehood imaginable about this bill in an effort to scare the American people and once again try to stymie reform.

But as I said, I believe that this year is different. Our legislation has been tested in public and the momentum continues to grow in support of the bill.

The American people have been heard through the lies and distortions.

And they are not fooled by the hoax of an 11th hour Republican bill that is nothing more than a cruel rebuke to the needs of the American people.

Their bill would do nothing but maintain the status quo and guarantee insurance profits at the expense of tens of millions of hard working Americans.

The public understands the true meaning of our bill.

They know it will cover 96 percent of Americans.

They know that, under our bill, if they lose their job they will continue to have health coverage for their children, spouses and families.

They know that this bill means that if they have cancer, the insurance company can no longer pull the rug out from under them while they’re in the middle of treatment.

They know that this bill will protect them, through any economic cycle.

Nearly 50 years ago, as he was fighting to expand health care benefits, President Kennedy said,

All of the great revolutionary movements of the Franklin Roosevelt Administration we now take for granted. But I refuse to see us live on the accomplishments of another generation. I refuse to see this country and all of us shrink from the struggles which are our responsibility in our time.

We must not shrink from the struggle for health reform, which is our responsibility in our time. This is our moment to revolutionize health care in this country.

We have arrived at this historic moment thanks to the hard work of so many people.

I would like to thank my good friends and colleagues, Chairman Rangel and Chairman Waxman, and our three subcommittee chairs, Rob Andrews, Frank Pallone and Pete Stark, and especially Dean Dingell. We could not have had better teammates in this journey.

I would also like to thank the Democratic Leadership, our Speaker, Ms. Pelosi, the Majority Leader, Mr. Hoyer, our Whip, Mr. Clyburn, and all the members of leadership for the countless hours they spent working with the committee chairs to arrive at this point today.

And of course we could not have completed the work on this bill without the work of our incredibly talented staff, who worked long nights and weekends for months on end. They are the unsung heroes of this process, and I know all our colleagues join me in thanking them for their extraordinary work.

From my staff I would like to thank Mark Zuckerman, Alex Nock, Danny Weiss, Michele Vamhagen, Megan O’Reilly, Jody Calemine, Tico Almeida, Meredith Regine, James Schroll, Rachel Racusen, Aaron Albright, Amy Peake, Courtney Rochelle, and Mike Kruger.

Finally, I’d like to pay tribute to my mentor and friend, Sen. Edward M. Kennedy.

Health care was the cause of Ted’s lifetime. His effort would have been impossible had he not carried the torch of justice and equality for all those years.

I know I am not alone when I say that I sincerely wish Ted Kennedy could be with us today to see his dream of quality, affordable health care for all become a reality.

Madam Speaker, this is the most important bill I have ever worked on during my many years of service in Congress.
American. The positive vote, the bipartisan vote on this bill is "no."

Mr. ANDREWS. Madam Speaker, I am pleased to yield to a Member who understands the immorality of 47 million uninsured. The gentleman from Michigan (Mr. KILDEE) is recognized for 1 minute.

Mr. KILDEE. I thank the gentleman. Madam Speaker, I rise today in strong support of H.R. 3962, the Affordable Health Care for America Act.

Choices regarding health care are some of the most personal decisions we make. The ability to choose one's doctor and decide on a course of treatment with one's physician is an undeniable American right, and so is access to quality affordable health care.

Most of us can agree that our current health insurance system is broken. The cost of health insurance has skyrocketed in recent years, leaving many families struggling to afford coverage or forcing them to go without. Others are denied insurance due to pre-existing conditions, saddling them with terrible medical debt when they need treatment.

These treatments, along with other factors, Madam Speaker, have led to nearly 30 million Americans without any health insurance; 71,000 live in my district.

I urge the passage of this bill.

Lack of adequate health coverage leads many people to wait until an emergency to seek medical treatment knowing what could have been a simple doctor's visit into a costly trip to the E.R. What many people do not realize is that when patients cannot pay their bills, the American taxpayer is charged for a portion of that cost. Medical providers also absorb some of the costs, forcing them to raise the prices of services and thereby increasing costs for everyone and driving up health insurance premiums. This problem will only get worse over time, and health care will continue to become more and more expensive.

The House health insurance reform legislation addresses this issue by increasing competition between insurers, thereby lowering costs. It also prevents insurers from denying or dropping coverage due to pre-existing conditions. By treating conditions earlier at a doctor's office, instead of at the emergency room, it will save money for the patient, the taxpayer and the medical providers, ultimately bringing down health care costs for everyone.

This is an issue that Congress has been tackling since the days of Harry Truman and even before then. Before I go on, let me thank my colleagues in passing this long-awaited bill.

Mr. KLINE of Minnesota. At this time, I am very pleased to yield 1 minute to the gentlelady from North Carolina, a former member of this committee and now a member of the Rules Committee, Dr. FOXX.

Ms. FOXX. I thank my colleague from Minnesota.

The people of America are struggling with 70 percent effective unemployment brought on by actions of this Democratically controlled government. And what do the Democrats want to do? Give us more government. They expect us to believe that more government control of our lives is good. More government control is not good.

We've been successful as a Nation because of our freedom. Taking away freedom will weaken us as a people and a country. The American people know that and have told us that. They're opposed to this bill.

Medicare, the kind of treatment they want us to have, denies treatment more than twice as often as most private insurance. That will be our future: rationed health care and destruction of freedom.

My colleagues should say no to the Pelosi-Obama freedom-killing, job-killing H.R. 3962.

Mr. ANDREWS. Madam Speaker, when people were about to be deprived the freedom to choose a public option, the Progressive Caucus stood up, the leader of the Progressive Caucus that led that effort will now be our next speaker.

The gentlewoman from California (Ms. WOOLSEY) is recognized for 2 minutes.

Ms. WOOLSEY. Thank you to Congressman ROB ANDREWS, who kept this clear and made it understandable for every single person in this country. Thank you, Congressman.

Well, let's put aside all the numbers and fuzzy terminology and let's talk about what this bill really means to average Americans.

Mr. ANDREWS. Madam Speaker, I will never forget 40 years ago waking up in the middle of the night with a start night after night after night because I did not have health insurance for my three small children, and it was not anything that had to do with anything that we had caused. I would wonder what would happen, what if my children got ill or one of them was injured because of no health insurance? Well, this bill that we're talking about today, with it, our family would have been secure. We would have been much healthier because we would have known that we had health insurance.

So, Madam Speaker, let's talk to a family of two, two working parents, two children. With this bill, if one of the children gets sick, the parents won't have to worry about arguing with the health insurance company for treatment. If the mother gets breast cancer, the family won't have to worry that their health insurance company will come along and say, because he doesn't want to pay for her treatment. If one of the parents loses his or her job, and along with it the family's health insurance, they will be able to go into the health exchange and choose between private and public plans. If the family can't afford to pay the premiums, there will be affordability credits to help them.

That security would have meant a better life for me. It would have meant a better life for my children that year. We want to make sure that every child has that security.

Mr. KLINE of Minnesota. At this time, I am very pleased to yield 1
minute to a very important member of the committee, the gentleman from Wisconsin (Mr. PETRI).

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

Mr. PETRI. I thank my colleague from Minnesota.

Madam Speaker, unemployment is 10.2 percent, the highest in 26 years, yet here we are being asked to vote on a bill which will radically alter and disrupt the sixth industry of our economy. It will businesses with costly new regulations, ratchet up monstrous Medicaid mandates on the 50 States, raise taxes on job creators, impose skyrocketing insurance premiums on individuals and families, and destroy popular Medicare Advantage plans, all this while failing to bend the cost curve down and providing no real liability reform.

At a time of record deficits, this bill spends over $1 trillion to provide health insurance to less than 15 percent of our population. To pay the least budgetary train wreck, it imposes $730 billion in new taxes and relies on a series of budget gimmicks in a slippery attempt to claim it won’t contribute to our deficit tsunami.

The legislation will bring about a radical intrusion of government into every sector of health care. It puts bureaucrats between patients and their doctors. It doesn’t make sense, isn’t very smart.

Let us not pass this monstrosity.

I certainly agree that it is time to fix the health care system in the United States so that all Americans have access to quality, affordable health care. In order to achieve this goal, I strongly believe that any bill that is approved by Congress must institute reforms that will address the rising cost of health care.

The majority of Americans have some kind of health insurance they are generally satisfied with. What they really care about is rising costs. Spending on health care services already accounts for about 17 percent of the GDP—an expected total of over $2.6 trillion in 2009. Health care inflation has outpaced general inflation by approximately 2.5 percent a year. Government spending on health care continues to grow exponen- tially and without action, spending on Medicare and Medicaid will rise from 4 percent to 19 percent of GDP in 2082.

However, the bill we are considering today takes us in the entirely wrong direction by in- stituting reforms that will increase health care spending by 30 percent, not bend the cost curve.

This legislation is best categorized as an entitlement expansion rather than health care reform. At a time of record deficits, H.R. 3962 imposes $729.5 billion in new taxes on small businesses, individuals who cannot af- ford health insurance, and employers who cannot afford to provide coverage that meets new insurance standards. In Wisconsin, the “surtax” that provides the largest source of funding for the bill will hit 11,900 small busi- nesses with no workforce compensation—hovering around nine percent. Individuals who are dependent on medical equipment such as wheelchairs and hearing aids will also face in- creased costs because of additional taxes in this bill—at a time when many families are struggling to pay their mortgages.

Furthermore, H.R. 3962 relies on a series of budget gimmicks to make it appear that the bill would not increase the federal deficit. First, the legislation fails to account for this year’s projected 21 percent cut to Medicare physician reimbursements, which if allowed to go through would severely threaten seniors’ access to physicians. However, preventing this and future cuts will cost over $200 billion. In- stead of making this fix in H.R. 3962 and ac- counting for its cost, the Democratic House leadership introduced it as a stand-alone bill that the Senate, which the Senate already rejected this approach. H.R. 3962 also proposes over $400 billion in cuts to Medicare. However, as many acknowledge, Congress has a history of reversing itself on unpopular cuts to Medicare, so it is very ques- tionable that this real savings will be realized. The legislation also authorizes a new long-term care program which is funded through a voluntary payroll tax. H.R. 3962 uses these pay roll contributions for other spending priorities in the bill, instead of the coverage. In Wisconsin, the Democ- rats or insurance companies, more re- cently the rhetoric of mandating extensive cost to provide coverage. Furthermore, the ex- tensive new federal record keeping and audit requirements provide further incentives to stop offering coverage. In fact, a study by Blue Cross and Blue Shield demonstrated that “complying with the new actuarial standards in the bill would increase average costs by 17 percent for individuals and almost 10 percent for small employers.

The bill imposes the money spent on health care in the United States today is spent on the delivery of health care. Yet, what we see in today’s bill is just “more of the same” in the delivery of care instead of making funda- mental changes to reward high quality, low cost care. The bill authorizes hundreds of Medicare pilot programs to test different ways to pay doctors and hospitals for quality of care. But once again, these pilots are gov- erned from the top-down and typically take years to initiate and rarely result in reforms applied throughout the system. Instead, we should be supporting efforts that are coming out of both the states and multi-collaborative projects between networks of hospitals, busi- nesses and physicians. Wisconsin hospitals such as ThedaCare, Marshfield Clinic, Gunderson Lutheran, and Aurora Health Care have long been engaged in transforming the delivery of care to get rid of the inefficiencies and provide low cost, high quality care. We should be supporting these reforms from the bottom-up, instead of repeating the work that has already been done.

And finally, I have grave concerns that the legislation will allow for government funding of abortions and threaten current conscience pro- tections for health care providers. I strongly believe that the Hyde Amendment should be codified in this legislation.

Today, I will vote in support of Congress- man BOEHRER’S substitute amendment which is a good step forward in lowering health care premiums for families and small businesses,
increasing access to affordable high quality care, and promoting healthier life styles—without adding to the deficit.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to heed the gavel.

Mr. ANDREWS. Madam Speaker, I yield myself 30 seconds before the next introduction.

There is a credibility issue here. The minority says the bill doesn’t have enough prevention, but the American Cancer Society supports the bill. The minority destroys the doctor-patient relationship, but the American Medical Association supports the bill. The minority says it’s bad for America’s seniors and for Medicare, but the AARP supports the bill. I think there is a credibility issue, and it doesn’t work for the minority.

At this time, I would be happy to yield 1 1/2 minutes to the gentleman from Pennsylvania (Mr. SESTAK).

Mr. SESTAK. Madam Speaker, a little short ago, I came to this Congress to pay back a debt. After three decades in the U.S. military, my young 4-year-old was struck with the same brain tumor Senator Ed Kennedy had. Because of the wonderful health care the Congress provides our families in the military, she was given a chance.

I am taken with this bill. It gives us healthy, productive workers. It actually combines, in my mind, the best of America’s character—rugged individualism allied with the common enterprise.

It gives us the quality of life that in the military reaps such great dividends. This bill, to me, is no different, and it’s time.

Mr. KLINE of Minnesota. Madam Speaker, at this time, I yield 2 minutes to the ranking member of the Armed Services Committee and the former ranking member of the Education and Labor Committee, the gentleman from California (Mr. McKEON).

Mr. McKEON. Madam Speaker, I thank the ranking member for yielding.

It’s been said that Abraham Lincoln said, “You cannot bring about prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the wage earners by taking away man’s initiative and independence. You cannot help men permanently by doing for them what they could and should do for themselves.” Madam Speaker, what we’re doing here violates all of these principles that Abraham Lincoln spoke so eloquently about.

I rise today in strong opposition to this Pelosi bill of over 2,000 pages. At a time when we’re suffering the highest unemployment in this country since 1983, the American people can’t afford these massive new spending increases, and I refuse to pass this great burden on to my children and grandchildren.

I would like to try to improve this bill: one to require Members of Congress to enroll in the public option like we’re going to require all of you to do, and one that said that illegal immigrants would not receive new benefits under this new bill; commonsense provisions that were voted down by the Democrats in the Rules Committee. In fact, Democrats voted down every single Republican amendment but one. How is that for bipartisanship?

This legislation increases taxes, kills jobs, and costs over $1 trillion in money we don’t have. The Republican plan will cut costs through tort reform, negotiating across State lines, and through purchasing power.

Support the Republican alternative and oppose the Pelosi plan. This is an absolute disaster.

Mr. ANDREWS. Madam Speaker, before I yield to my next speaker, I yield myself 30 seconds.

With all due respect, what is an absolute disaster are the repeated misrepresentations of certain things that are in this bill, and what I just heard. One is the forced intersection. No one is forced to join the public option. No one. It is not in the bill, and I would, frankly, invite the minority to show us where it is.

Secondly, Members of Congress are positioned exactly the same everyone else is with the public option. When and if the time comes that the Federal Government is a participating employer in the exchange, we can either choose the public option or not. The House deserves an accurate record.

I yield 1 1/2 minutes to a woman who stood for fiscal soundness not only here in Washington but in New Hampshire for her State budget, the gentlewoman from New Hampshire, CAROL SHEA-PORTER.

Ms. SHEA-PORTER. Madam Speaker, I rise today to support the Affordable Health Care for America Act. This is a historic moment for our Nation.

In my district, this bill will provide coverage for 37,000 uninsured residents; 128,000 households will qualify for credits to help them afford the coverage of their choice. We will invest more in community health centers. We make Medicare stronger, which is why AARP has endorsed this bill. We start to close the Medicare Part D doughnut hole in 2010, and it will be completely closed by 2019. We will provide a 50 percent discount for name-brand drugs for those in the doughnut hole, and we eliminate copayments for preventative care.

Today, we make history for our seniors, for our children, for the middle class—for all Americans. Today, we vote for an America where discrimination based on preexisting conditions is a thing of the past. Today, we vote for an America where getting sick doesn’t mean losing your home. Today, after decades of debate, we finally vote for a healthier America.

Mr. KLINE of Minnesota. Madam Speaker, before I yield to the gentlewoman from Washington, I yield for a unanimous consent request to the gentleman from Kentucky (Mr. ROGERS).

Mr. ROGERS of Kentucky asked and was given permission to revise and extend his remarks.

Mr. ROGERS of Kentucky. Madam Speaker, I rise in opposition to this Freedom-taking bill.

We can all agree that health care costs are too high and that we need to open up access for more Americans. That being said, we need to pass a bill that actually cuts costs and increases access rather than a government-run takeover of health care. I cannot support Speaker PELOSI’s monstrosity of a bill because it puts a Washington bureaucrat between individuals and their doctor, it adds to our enormous debt in Washington, and, even more frightening, it will limit health care availability in rural regions like southern and eastern Kentucky.

In these challenging economic times, with double digit unemployment, out of control government spending sprees, and bailouts after bailouts, we should not pass a bill that will kill jobs, raise taxes, and raise premiums for government-run health care bill not only imposes new penalties and taxes on small businesses, it raises taxes on already struggling individuals and families. Whether someone wants health insurance or not, they’ll be forced to purchase it, and the federal government will garnish wages or send them to jail if they don’t comply. Even more troubling, the more vulnerable and ailing one is, the more they’ll pay, as this bill imposes new taxes on critical medical suppliers, home health care, wheelchair beds, and prosthetic limbs. As if that wasn’t enough, the bill opens the floodgates of taxpayer money for illegal immigrants to abuse the system and obtain free government health insurance—all on the backs of law-abiding Americans.

I rise today in strong opposition to this Freedom-taking bill.
Mr. KLINE of Minnesota. I am now pleased to yield 2 minutes to the ranking member of the committee, the gentleman from Washington, CATHY MCMORRIS RODGERS.

Mrs. MCMORRIS RODGERS. I thank the gentlewoman for yielding.

Madam Speaker, we just need to slow down. The American public has made it clear that they want the right health care reform bill enacted, not just any bill.

Look at the stimulus bill that was rushed through Congress. Look at what has happened. They said, Oh, unemployment won’t go over 8 percent. We are now at 10.2 percent. We have lost 3 million jobs, and we have a $1.4 trillion deficit.

Like my mom used to say, You rush, you make mistakes.

This health care reform bill will be no different. It spends $1.3 trillion. It taxes employers $750 billion, many of whom are small business owners, at the very time that we need these small business owners to be creating jobs. We need jobs. Isn’t it interesting that even the administration’s own economic adviser has estimated that this bill will cost America an additional 5.5 million jobs.

Other reforms in the bill will eliminate Medicare Advantage, hurting 20,000 seniors in eastern Washington and millions across the country. For rural communities, the bill calls on the Institute of Medicine to study payment disparities in rural regions. So we are spending $1.5 trillion, and the only relief we get is another study? My list of concerns goes on and on.

The Republicans have a better way, one that lowers premiums for families by as much as 10 percent; one that saves billions in medical liability reform, allowing people to purchase health insurance across State lines; one that continues the continuity and coverage; and it’s a solution that doesn’t indebted our children and our grandchildren.

Madam Speaker, just this week, thousands of people stood on the Capitol steps. They called on Congress to oppose this legislation. I urge us to heed their warning. Vote “no.” Let’s slow down the process, and let’s get the right kind of reform, not just any kind of reform.

Mr. ANDREWS. Madam Speaker, I yield myself 15 seconds.

The gentlewoman just quoted an unnamed phantom Obama administration adviser, Christina Romer, the CEA chairperson for the Obama administration, says this bill will increase the GDP between 1-2 percent and will add several million jobs.

I am pleased to yield 1½ minutes to a strong voice for working families in this country, the gentleman from Illinois (Mr. HARE).

Mr. HARE. Thank you, Congressman ANDREWS.

Madam Speaker, when I was growing up as a young boy, my parents lost their home. My father was ill. He couldn’t make the payments. I remember coming home the day of my older sister’s wedding to see a process server with a notice to evict and 30 days to leave.

Two days before my father died, I sat by his bed, and he told me, There are two promises I want you to make to me: take care of the girls and your mother, and no matter what you do, please see that this will not happen to another family.

Tonight, in a few hours, I will have the opportunity to keep that promise to my dad and to the tens of thousands of other people who have lost their homes and everything they had simply because they were sick. All the fearmongering. All the misstatements of facts and figures. Health care in this country, my friends and fellow citizens, is a right. It is not a privilege.

So, tonight, for my father and for the people who came after him, I will stand proudly for this bill no matter the amount of shouting, of tearing this down and of calling the bill whatever you want to call it. I call it getting people exactly what this country promises them: life, liberty, and the pursuit of happiness.

Mr. KLINE of Minnesota. Madam Speaker, I am pleased to yield 1 minute to a member of the committee, the gentleman from Michigan (Mr. HOEKSTRA).

Mr. HOEKSTRA. I thank my colleagues for yielding.

Madam Speaker, today, I met Theresa. Theresa had a sign that read: I love my country. On the other side, it read: My future. Her brother, Xavier, had a sign that read: Give me liberty, not debt.

If we pass Pelosi health care tonight, tomorrow morning, we will still all love our country; but we will have jeopardized Theresa’s future. A bailout, a stimulus, cap-and-trade, and Pelosi health care have jeopardized her future. For Xavier, we will have given him debt: another $1.2 trillion on top of the $1.4 trillion we gave him last year.

I will vote “no” because I believe that that is the vote that says: I love my country. I will vote “no” because I believe that is the vote that preserves our future. I will vote “no” because I know that that will preserve Xavier’s liberty and not give him more debt.

With that, I urge my colleagues to vote “no” on this bill.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 1½ minutes to a member who fought tirelessly for the Affordable Health Care for America Act (H.R. 3962), the Affordable Health Care for America Act does not reflect the access or affordability needs of NFIB’s small businesses and a vote today will be considered an NFIB Key Vote for the 111th Congress.

Mr. LOEBSACK. Thank you, Mr. ANDREWS.

Madam Speaker, I am proud to be a part of this effort to improve health care in America, and I will support the bill before us because I have heard from countless Iowans about the desperate need to change the current system, and I believe this legislation before us today will provide true and comprehensive reform.

However, since coming to Congress, I have told about everyone I could and everyone who would listen to me that comprehensive reform can not be achieved without addressing geographic disparities in the Medicare payment system. Many other Members of Congress agreed, and we formed the Quality Care Coalition, and we brought about that change.

There is much needed language in this bill to fix a broken Medicare payment system. By focusing now on the quality of services provided to patients instead of the quantity of services, this provision will provide a significant cost savings to Medicare, and it will benefit patients in Iowa and all across America.

In particular, I want to thank my leadership; my chairman on the committee, GEORGE MILLER; my friend ROB ANDREWS; CHAIRMAN WAXMAN; and CHAIRMAN RANGEL for their work on this issue.

I urge everyone to vote for this bill before us.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the committee, the gentleman from South Carolina (Mr. WILSON).

Mr. WILSON of South Carolina. Madam Speaker, America’s leading voice for small business, the National Federation of Independent Business, the NFIB, opposes H.R. 3962, the Pelosi takeover bill. The NFIB has sounded the alarm about the employer mandate, payroll tax penalty and unnecessary paperwork mandate crippling small businesses.

The opposition letter from the NFIB warns that the Pelosi takeover includes multiple mandates. Economic research shows mandates are ultimately borne by the worker through job loss and lower wages. The NFIB also warns how the payroll tax penalty is a tax on jobs and job creation. Additionally, the unnecessary paperwork mandate will place a new paperwork burden on all small businesses at a time when they are struggling to stay afloat. The NFIB has estimated the taxpayer effort will kill 1.6 million jobs at a time of record unemployment.

We should support health insurance reform, not a government takeover.

November 5, 2009.

LETTER TO HOUSE OPPOSING H.R. 3962

DEAR REPRESENTATIVE: On behalf of the National Federation of Independent Business (NFIB), the nation’s leading small business advocacy group, I am writing in opposition to the Affordable Health Care for America Act (H.R. 3962). The Affordable Health Care for America Act does not reflect the access or affordability needs of NFIB’s small businesses and a vote today will be considered an NFIB Key Vote for the 111th Congress.

Mr. LOEBSACK. Thank you, Mr. ANDREWS.

Madam Speaker, I am proud to be a part of this effort to improve health care in America, and I will support the bill before us because I have heard from countless Iowans about the desperate need to change the current system, and I believe this legislation before us today will provide true and comprehensive reform.

However, since coming to Congress, I have told about everyone I could and everyone who would listen to me that comprehensive reform can not be achieved without addressing geographic disparities in the Medicare payment system. Many other Members of Congress agreed, and we formed the Quality Care Coalition, and we brought about that change.

There is much needed language in this bill to fix a broken Medicare payment system. By focusing now on the quality of services provided to patients instead of the quantity of services, this provision will provide a significant cost savings to Medicare, and it will benefit patients in Iowa and all across America.

In particular, I want to thank my leadership; my chairman on the committee, GEORGE MILLER; my friend ROB ANDREWS; CHAIRMAN WAXMAN; and CHAIRMAN RANGEL for their work on this issue.

I urge everyone to vote for this bill before us.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the committee, the gentleman from South Carolina (Mr. WILSON).

Mr. WILSON of South Carolina. Madam Speaker, America’s leading voice for small business, the National Federation of Independent Business, the NFIB, opposes H.R. 3962, the Pelosi takeover bill. The NFIB has sounded the alarm about the employer mandate, payroll tax penalty and unnecessary paperwork mandate crippling small businesses.

The opposition letter from the NFIB warns that the Pelosi takeover includes multiple mandates. Economic research shows mandates are ultimately borne by the worker through job loss and lower wages. The NFIB also warns how the payroll tax penalty is a tax on jobs and job creation. Additionally, the unnecessary paperwork mandate will place a new paperwork burden on all small businesses at a time when they are struggling to stay afloat. The NFIB has estimated the taxpayer effort will kill 1.6 million jobs at a time of record unemployment.

We should support health insurance reform, not a government takeover.

November 5, 2009.

LETTER TO HOUSE OPPOSING H.R. 3962

DEAR REPRESENTATIVE: On behalf of the National Federation of Independent Business (NFIB), the nation’s leading small business advocacy group, I am writing in opposition to the Affordable Health Care for America Act (H.R. 3962). The Affordable Health Care for America Act does not reflect the access or affordability needs of NFIB’s small businesses and a vote today will be considered an NFIB Key Vote for the 111th Congress.
NFIB has been a constructive participant in the healthcare debate and has spent more than a decade voicing our need for reform. With healthcare costs ranking as the No. 1 issue facing small businesses, our members must weigh the potential benefits of reform against the new costs imposed on business owners in the legislation. NFIB members have identified specific areas in H.R. 3962 that will raise those costs:

Employer Mandate: H.R. 3962 includes an employer mandate that will require employers to offer healthcare for full-time and part-time employees. An employer mandate does not address the No. 1 issue facing small businesses: affordable costs. This mandate affects those who do not offer coverage today as well as those who already do provide insurance, but aren’t making contributions at contribution levels outlined in the bill (72.5% for individual plans and 65% for family plans). Rather than help, this will penalize employers already offering healthcare and force them to make hard choices about how to afford the new government requirements. Economic research has shown time and again that mandates such as these are a “one-two punch” that shifts the cost burden to the employer, but is ultimately borne by the employee—through job loss and lower wages.

Payroll Tax Penalty: A payroll tax penalty is a tax on jobs and job creation because they tax labor. The legislation requires that all employers with a payroll of $500,000 or more pay a surcharge of up to 8 percent if they do not provide “qualified” health insurance to their employees. No matter how profitable or unprofitable a business might be, it will now have to pay this tax. In addition, because the exemption thresholds in H.R. 3962 are not indexed for inflation, the exemption will become a healthcare equivalent of the minimum tax. This means it will be hard if not impossible to pay a payroll tax penalty and a minimum tax at the same (or even similar) payroll size.

Paperwork Mandate: H.R. 3962 places a new tax-compliance paperwork burden on all small businesses. The “corporate reporting” provision is an expansion on reporting requirements (for transactions of more than $600) that increases the cost of operating a small business and diverts resources away from growing and creating jobs.

Big Business, Big Mandates: Small employers need a guarantee that plans offered in an exchange will be less costly, not severally reduce the amount of a tax credit available for most small businesses. NFIB will continue to advocate for reform because, as both democratic and republican lawmakers have said, the status quo is not acceptable. Our small business owners agree, but reform must be fiscally sound and not worse. Because H.R. 3962 will not lower healthcare costs and threatens our economic recovery, NFIB will offer a NO vote in support of small business. This will be an NFIB KEY VOTE FOR THE 111TH CONGRESS.

Sincerely,
SUSAN ECKERLY
Senior Vice President, Federal Public Policy.

Mr. ANDREWS. Madam Speaker, I yield 2 minutes to a gentlewoman who authored a provision to expand small business opportunities for affordable health insurance, the gentleman from Nevada (Ms. TITUS).

Ms. TITUS. Thank you, Mr. ANDREWS.

Madam Speaker, for more than 6 months, I’ve discussed the need for health care reform with my constituents; and time and again I’ve heard from small business owners who are struggling to afford health care coverage.

Over the last decade, the average health insurance premium has more than doubled for Nevada’s small businesses. Without comprehensive reform, Nevada’s small business health premiums are projected to again double over the next decade. In this year alone, small businesses across the country are being hit with a 15 percent average increase in premiums. It is clear that the status quo is unaccept- able and unsustainable.

I had concerns about earlier versions of this bill, but I am pleased that H.R. 3962 before us today is significantly improved and takes important steps to help make health insurance more affordable.

I worked to raise the income level at which people are assessed a health care surcharge. The new threshold is significantly higher, up from $350,000 for couples to $1 million. This means that 98.8 percent of all small businesses will be exempt from this surcharge.

The bill also now exempts small businesses with payrolls below $500,000 from the employer mandate. That means that 86 percent of all employers are exempt, and many small businesses which choose to offer insurance to their employees will be eligible for a tax credit to help offset those costs. I am especially proud that the provision I championed, which was to exclude 98.8 percent of American small businesses, was included and strengthened in this bill. This will ensure that small businesses have additional options for purchasing health insurance at a lower cost.

All of these improvements combined will strengthen small businesses so they will be critical engines of growth in our communities. It is time small businesses knew who really stood up for them and cared about them and their employees.

I urge my colleagues to support this bill and to stand up for small business.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the Committee from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. I thank the gentleman for yielding.

Madam Speaker, I rise in strong opposition to this $1.3 trillion government takeover of healthcare.

Time and again, the President promised the American people that, if they like the health insurance they have, they can keep it. So I introduced an amendment in the Education Committee that said what he said: if you like the health insurance you have, you can keep it.

The Democrats defeated this amendment with a unanimous vote.

This bill does not keep the President’s promise. Instead, it would allow a group of unelected government bureaucrats to determine if the health insurance you have is up to government standards. If they say it’s not and if you don’t buy what they say you should buy, you will be fined. If you don’t pay the fine, it’s jail time.

I urge my colleagues to defeat the bill and, to instead, vote for the GOP alternative. Not only does it expand access to those who lack it and not only does it lower costs for everyone, but it cuts the deficit, preserves the doctor-patient relationship, and ensures that you can keep the coverage you have.

Mr. ANDREWS. Madam Speaker, a number of great and visionary men have stood at the podium where you stand now as Speaker of the House. Many of them tried to achieve significant health care reform; each of them failed. It’s time for a new generation of lawmakers to make health care affordable and accessible and pass comprehensive reform that will strengthen small businesses so they will be critical engines of growth in our communities. It is time for the President to listen to his colleagues in the House who are standing with us to achieve this historic goal.

Sincerely,
ROB ANDREWS
Madam Speaker, today as we all know is an historic moment for our Nation and for America’s families. For nearly a century, leaders of every party and political philosophy have, as far back as Teddy Roosevelt, called for health care for the American people.

For generations, the American people have called for affordable, quality health care for their families. Today, the call will be answered. Today, we will pass the Affordable Health Care for America Act.

This legislation is founded on key principles for a healthier America: innovation, competition and prevention. It improves quality, lowers cost, expands coverage to 36 million more people, and retains choices.

Our innovation began in the recovery package in January with $19 billion for health IT, the first step in lowering cost and improving quality, and $3 billion in investments for biomedical research. This legislation will mean affordable health care for the middle class; no dropped coverage if you are sick; no copays for preventive care. There is a cap on what you pay in, but there is no cap on the benefit that you receive.

It works for seniors, closing the doughnut hole, offering better primary care and strengthening Medicare for years to come. It works for women, preventing insurance companies from charging women more than men for the same coverage. No longer will being a woman be a preexisting medical condition.

It works for young people, offers affordable choices and copays for preventive care to stop problems before they start, and allows young people to stay on their insurance until their 27th birthday. It works for small business owners, providing access to affordable group rates and creating a tax credit to help them insure their employees. It works for consumers, keeping insurance companies honest and encouraging competition with a public option.

This legislation puts you and your doctor in charge. No longer will the insurance companies come between you and your care.

President Obama has said that health care reform is entitlement reform, and this legislation proves that point. It is fiscally sound, it is paid for, and it reduces the deficit by tens of billions of dollars over the next 10 years.

This legislation is the result of extensive deliberation here in the Congress, where we have held more than 100 hearings and is the product of extensive input from the American people. Members of Congress have held over 3,000 town meetings. It has resulted in a better bill than H.R. 3200. However good or excellent that was, this bill is a better one with significant differences, and my colleagues have pointed them out, as did Congresswoman DINA TITUS, who just spoke before me at the podium.

We are brought to this historic moment in our Nation for our families because of leaders: Chairman HENRY WAXMAN of the Energy and Commerce Committee, Chairman CHARLIE RANGEL of the Ways and Means Committee, Chairman GEORGE MILLER of the Education and Labor Committee, and Chairwoman LOUISE SLAUGHTER of the Rules Committee. I thank all of those committees, including the Rules Committee, for being in so late so that we could have this legislation on the floor today and for their own efforts good for our communities.

More than 300 groups representing tens of millions of Americans have expressed their support for the bill: the AARP, American Medical Association, the American Nurses Association; the list of medical groups goes on and on.

The American Cancer Society Cancer Action Network, American Heart Association, American Diabetes Association. And I am particularly proud the Consumers Union praised the legislation. My colleagues, this morning we were part of history, and we are this evening as well.

But a particularly poignant moment occurred when Chairman DINGELL took the Chair to preside over the debate, the beginning of the debate for health care. When he was a young man as a Member of Congress, he gavelled Medicare into law. It had been, as one of our colleagues said, in his DNA, this pursuit of the safety net for all Americans.

His father had introduced the bill over and over again when he was in Congress and, as his successor, he continued that great legacy. Today he will see a lifelong dream of generations in his family come within the process of making this a reality.

It’s impossible to talk about health care reform in America without talking about Senator Edward Kennedy. His leadership, his commitment to this debate is boundless. Health insurance reform was the cause of his life. He called it “the great unfinished business of our society.” On this issue he said what is at stake “is the character of our country.” When the President came to address the joint session, he quoted those comments by Senator Kennedy from a letter that the Senator had sent to him. What the Senator also said in the letter that was sent to President Obama before he died was this:

“I entered public life with a young President who inspired a generation and the world. It gives me great hope that as I leave, another young President inspires another generation and once more on America’s behalf, inspires the entire world.”

He acknowledged President Obama’s “unwavering commitment and understanding that health care is a decisive issue for our future prosperity.”

President Obama’s leadership gives us our Nation hope. Today, with this legislation, we will give them health.

President Obama has said, “We will measure our success in the progress that is made by America’s working families.”

Today, with the passage of the Affordable Health Care for America Act, we will make history. We will also make progress for America’s working families.

I urge my colleagues to support this important legislation.

Mr. SOUDER. Mr. Speaker, at this time I am pleased to yield 1 minute to someone who tells me that he is, in fact, very proud he doesn’t have a section in this bill, a member of the committee, the gentleman from Indiana (Mr. SOUDER).

Mr. SOUDER. This is indeed a historic day. It’s a crossroads in America. What you just heard from our distinguished Speaker was we, the government, will do this. We, the government, will do that. We, the government, will do that. Instead of having the private sector do this, instead of having competition, instead of having capitalism do this, we, the government, will fix everything. We, the government, will provide everything.

We are in an economic crisis in this country. Just yesterday, for the first time, an over 10 percent unemployment. In my eight counties, over half are over 15 percent unemployment.

What are we doing today? Taxing small business, the number one producer of jobs, adding regulations to those businesses, adding expenses to those businesses, taxing medical technology, which will reduce R&D, reduce jobs, reduce quality of health care.

What are we doing today? We are not going to require identification for illegal immigrants. We are going to hope that they self-report. With 1,990 pages of ignoring the voices of American people, paying higher taxes, fewer jobs, an unconstitutional takeover of 17 percent of our economy, a trillion dollars of debt, and free health care for the illegals who took your jobs.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 2 minutes to the gentleman who made sure that the ban on discrimination based on preexisting conditions will take effect as soon as this bill does, the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Madam Speaker. 45 percent of Americans suffer from some form of chronic disease, leaving them exposed to preexisting condition discrimination. The Commonwealth Fund found that 12.6 million non-elderly adults were, in fact, discriminated against. As I yield to the next gentleman, I yield to the gentleman from Connecticut who made sure that the ban on discrimination based on preexisting conditions will take effect as soon as this bill does.
the right to vote or own property, the practice of denying coverage because of a person's internal biology, high blood pressure, diabetes or cancer will be forever abolished.

Section 211 of this bill ends this practice permanently in 2013; and section 106, which I wrote with Mr. ANDREWS' help, immediately provides relief by amending existing law to shorten the look-back period for group health plans from 6 months to 30 days and reduces the exclusion of coverage for pre-existing conditions from 18 months to 90 days.

This balanced, well-thought-out reform of the Health Insurance Portability and Accountability Act of 1996 will provide tangible, real change for Americans terrified of losing their coverage because of a layoff or a job change.

What does the Republican plan do? Does it adopt section 106 or 211? No. On page 145 of the Republican bill, they call the look-back period—especially for the exclusion of coverage for pre-existing conditions. The time for delay and dilatory studies is over. It is time to act.

As U.S. President Abraham Lincoln once said, it is time to make a more perfect union, and pass the Affordable Care Act. When we passed this bill, it is time to make the Affordable Health Care Act for America Act.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1½ minutes to a distinguished member of the committee, the gentleman from Delaware (Mr. CASTLE).

Mr. CASTLE. Mr. Speaker, I rise in opposition to the legislation but in strong belief that the vast majority of us in Congress are committed to reducing the skyrocketing costs of health care today and expanding access to insurance coverage for those in need.

Additionally, I am certain that if we focused on the on the many shared bipartisan goals, we could pass a health reform package that took common-sense steps without making financial commitments that this country is unable to afford. Such items include insurance market reforms such as preventing denial of care for preexisting conditions, purchasing insurance across State lines, encouraging regional exchanges between States and portability, small business pooling and tax credits, negotiating drug prices, eliminating the $60 billion in Medicare fraud each year, rewarding efforts to prevent common disease and illness, enrolling those who qualify into existing programs like Medicaid and SCHIP, tax benefits for needy individuals for help purchasing insurance, and limiting abusive lawsuits.

Instead, we are confronted with a bill that overreaches by creating new government programs costing over $1 trillion paid for from tax increases and cuts to Medicare which are more gimmicks than real entitlement reform. Independent analysis of H.R. 3962 continues to show that this bill will result in higher costs for too many patients in addition to increasing the Federal debt which continues to rise dramati-

-- Mr. ANDREWS. Mr. Speaker, the Affordable Health Care Act: a call for— are you ready—a GAO study page 145 of the Republican bill, they reduce the cost of health care for individuals and families. It will provide relief for nearly 17 million by reducing co-payments for seniors, reducing premiums by over $10 billion, contains costs and limits government involvement.

Where are we today? Our country spends more and gets less from health care. We spend more and get less. Many small businesses and individuals are unable to afford insurance. Americans are fed up with 15 to 20 percent increases in costs every year, and that is for those of us lucky enough to have insurance. People with preexisting conditions often can't get coverage, or the very condition they need coverage for is excluded.

Where does this bill take us? It encourages competition among insurance companies, giving us more choices and more stability so we can choose from hundreds of different policies, including shopping across State lines. It covers most of the uninsured by empowering them to choose the provider of their choice. It prevents pricing discrimination based on preexisting conditions. It allows small businesses to have the same purchasing power as large corporations and saves them money. It renews our legal system to reduce the cost of frivolous lawsuits. It supports doctor and nurse training, reduced the deficit by over $10 billion, and applies free market principles to establish a playing field for health care that is good for practitioners and consumers.

I encourage my colleagues to support health care.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentleman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. Speaker PELOSI's plan lacks the necessary tools to prevent an arbitrary cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without families face.

I am voting “no” on Speaker PELOSI's bill because of the devastating consequences it will have on Kentucky's families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, I rise to talk about Speaker PELOSI's bill. Thank you for your leadership in this effort, Mr. Speaker. The Affordable Health Care Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care.

Most importantly, the Affordable Health Care Act provides savings and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote “yes” on H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. Speaker PELOSI's plan cuts Medicare benefits, includes a $34 billion unfunded Medicaid mandate and increases premiums for those already struggling to pay for health insurance. Everyone in this country is concerned about this bill, raises taxes for just about everyone. The bill taxes individuals who choose not to purchase health insurance, taxes small businesses, taxes medical devices, and taxes health savings plans. The bill is the exact opposite of what the American people said they wanted. The Republican alternative addresses Americans' number one priority for health care reform: lowering the cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without taxing families and small businesses.

I am voting “no” on Speaker PELOSI's bill because of the devastating consequences it will have on Kentucky's families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. The Affordable Health Care Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care.

Most importantly, the Affordable Health Care Act provides savings and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote “yes” on H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. Speaker PELOSI's plan lacks the necessary tools to prevent an arbitrary cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without families face.

I am voting “no” on Speaker PELOSI's bill because of the devastating consequences it will have on Kentucky's families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. The Affordable Health Care Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care.

Most importantly, the Affordable Health Care Act provides savings and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote “yes” on H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. Speaker PELOSI's plan lacks the necessary tools to prevent an arbitrary cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without families face.

I am voting “no” on Speaker PELOSI's bill because of the devastating consequences it will have on Kentucky's families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, I rise to talk about Speaker PELOSI's plan. The Affordable Health Care Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care.

Most importantly, the Affordable Health Care Act provides savings and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote “yes” on H.R. 3962.
body is set to send my State another unfunded mandate estimated to cost $230 million. And the deficit just exceeded $1.3 trillion; yet the majority wants to pass this $1.3 trillion government takeover of health care.

Let’s reject this fiscally irresponsible legislation.

Mr. ANDREWS. Mr. Speaker, may I inquire as to how much time each side has left?

The SPEAKER pro tempore (Mr. PASTOR of Arizona). The gentleman from New Jersey has 18 minutes remaining, and the gentleman from Minnesota has 21 minutes remaining.

Mr. ANDREWS. Mr. Speaker, I am very pleased to yield 1 minute to the newest member of our committee, who has made a tremendous contribution to this bill already, the gentlelady from California (Ms. CHU).

Mr. Speaker, I rise in strong support of the Affordable Health Care for America Act. The clock is ticking for Americans and the children of my district. Families have been suffering for changes in our health care system so they can care for their children. They have been waiting for Congress to act.

They are mothers like Maria, whose child has leukemia and worries that excessive copays will make her go bankrupt.

They are children like Stacey, who has been waiting to get glasses and can’t see the chalkboard at school, but she can’t get them because her parents’ insurance doesn’t provide vision care.

They are parents like Barbara and Jim, whose 20-year-old has diabetes and is no longer eligible for health insurance since he graduated from college.

With the passage of this bill, out-of-pocket expenses will be capped at $10,000, vision care for children will be covered, and older children will be covered up until age 26. Maria will not go bankrupt. She will get glasses, and a son with diabetes can get treated. Children and families will get the quality health care they deserve.

Let’s pass this health care bill now.

Mr. KLINGE of Minnesota. Mr. Speaker, at this time I am pleased to yield 1 minute to a member of the committee, a practicing physician himself, the gentleman from Louisiana (Dr. CASSIDY).

Mr. CASSIDY. Mr. Speaker, as a practicing physician, I know that this bill has tremendous consequences for patients and for the economy. It is estimated that the $730 billion in new taxes in this bill will kill 5.5 million jobs. The CBO estimates that this will have an annual inflation rate of 8 percent, an annual inflation rate that more than doubles costs in 10 years.

The Republican bill expands access by lowering premiums 10 percent. This bill expands access by forcing businesses and individuals to purchase, and if they do not, the long arm of the State reaches out and grabs them and shakes out fees and penalties.

Now, it was said this morning by a Democratic colleague that we need to redefine freedom. We are going to need all kinds of new definitions. We are going to redefine freedom as the ability to do what the government tells you to do. We are going to redefine helping the sick as being in the insurance business, and destroying jobs. We are going to redefine bailing the cost curve as more than doubling costs in 10 years.

Consider not the rhetoric, but the facts. Please reject this bill.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 1/2 minutes to the gentleman from New Jersey, my neighbor and friend, Mr. HOLT.

Mr. HOLT. Mr. Speaker, the question many are asking is, Can we afford this health care reform? I would say not only can we afford it, we can’t afford not to pass it.

Consider where we are today: Businesses, large and small, feel a heavy weight because they are trying to afford health care for their employees. It hurts our economy. It costs jobs. Businesses and families are paying a hidden tax of over $1,000 each year for the care of the uninsured. Costs continue to go up because our procedure-based system rewards the ordering of unnecessary and expensive tests that not only don’t help the patient, they can be detrimental. Any family, even well-off families who think they have good health coverage, can find themselves in bankruptcy from a bad accident or arbitrary actions of the insurers.

All of this would change under this bill. This bill would reduce costs in a number of ways: By reducing the ranks of the uninsured, whose more expensive care we all pay for; by increasing the insurance competition through the new marketplace with a large interstate risk pool; by removing the antitrust exemption; and by moving toward more efficient and by moving toward more outcome-based, health outcome-based, patient-centered care.

In addition to all this, the revenues raised by this bill exceed the expenditures, so passing this will reduce the deficit by billions of dollars below what it would be if we do not pass this tonight.

We can’t afford not to pass this health care reform. The bill will reduce the costs individuals, families and businesses face and reduce the government deficit.

Mr. HOLT. Mr. Speaker, I rise today in strong support of the Affordable Health Care for America Act, H.R. 3962, legislation that would provide secure and stable health coverage regardless of whether one changes jobs or is between jobs, ensure Americans will never be forced to enroll. The bill also would be just that—an option in which no one has to go to a health care provider, but can create in New Jersey, while others lack even biotechnology and pharmaceutical products created in New Jersey, while others lack even basic care. One of the goals of the health care reform is to help all Americans gain stable access to quality medical care and life-saving medicines.

At a July roundtable in Trenton, a spouse of a cancer patient told me that when she and her husband came home from the hospital after an extensive treatment needed to save her foot-high stacks of insurance paperwork and $150,000 of out-of-pocket charges for her husband’s needed care. A self-employed woman from East Brunswick wrote to me recently to let me know she pays $2,000 a month for her family’s coverage and still has to pay out-of-pocket to see many of her physicians. These stories are a reminder that health care reform is about real people who are disserved by the broken health insurance system.

These are not isolated stories. While in the U.S., we will spend over $8,000 per person through 2019 for health care. New Jerseyans lacked insurance in 2007 and family insurance premiums are projected to rise from $14,000 in 2009 to $24,000 in 2019. In a county where we are projected to spend 18 percent of our Gross Domestic Product ($2.6 trillion) by the year 2012 on health care, we can do better.

The Affordable Health Care for America Act would improve the American health care system for all Americans, regardless of how they currently receive their health coverage. First, the legislation would lead to stable health costs that do not threaten family finances by establishing consumer protections for those purchasing private insurance. The bill would eliminate insurance benefit caps to ensure families do not have to worry about leaving the hospital with bills too big to pay because their benefits have run out. The bill would set an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.

Second, the bill would provide stable coverage for those between jobs or the self-employed by creating an insurance marketplace, where they could get insurance at group rates. Most of the policies in this insurance marketplace would be private insurance, while one of the plans would be a non-profit public plan. This public plan would be subject to the same requirements and regulations as the for-profit plans in the marketplace. The public option would be just that—an option in which no one would be forced to enroll. The bill also would eliminate the practice where patients with a pre-existing condition like diabetes or cancer or pregnancy cannot purchase insurance. According to a Congressional committee report, the bill would help 10,000 uninsured individuals in Central New Jersey gain access to affordable health insurance.

Third, the bill would strengthen Medicare by starting to pay physicians for treating the whole patient and by encouraging doctors to coordinate a patient’s medical care instead of paying for each test or procedure. The legislation would strengthen the long-term health of the Medicare trust fund by increasing the efficiency of the program, expanding its ability to prevent fraud, waste, theft, and abuse, and eliminating wasteful subsidies to private insurance companies.
It is worth repeating; not only would Medicare remain intact under this legislation, it would become better. The legislation would strengthen the Medicare trust fund by increasing the efficiency of the program, expanding its ability to fight waste, fraud, and abuse, and eliminating subsidies to private insurance companies. No standard Medicare benefits would be cut. In fact, Medicare would be improved by eliminating the “doughnut hole” in the prescription drug benefit. Each year in Central New Jersey, 8,300 seniors face the “doughnut hole” and are forced to pay their full drug costs, despite paying for Part D drug coverage every month. H.R. 3962 would provide these seniors with immediate relief by cutting brand name drug costs in the “doughnut hole” by 50 percent and ultimately eliminating the “doughnut hole” altogether. Further, the legislation would help seniors by eliminating co-payments and deductibles in Medicare for preventative services to ensure that diseases would be treated at their earliest stages and to keep seniors well. The legislation creates new Medicare incentives to encourage hospitals to coordinate medical care and seek to reduce duplicate tests, x-rays, and labs. These and other provisions are why AARP, among several others, has endorsed this health care reform legislation.

This bill was created from one of the most open and deliberative processes in recent memory. During the past few years, Congressional committees held more than 53 committee hearings, debated and voted on almost 240 amendments, and considered health reform for 167 hours. Many of the amendments reflected concerns raised by constituents and have improved this bill further.

While there are strong humane and moral reasons to pass this health reform bill, the economic reasons are equally strong. Businesses, large and small, feel a heavy weight in trying to afford health care for their employees—hurting the economy and costing jobs. Any family, regardless of their income, can find themselves in bankruptcy from one accident or expensive illness. All of this would change under this reform bill. The legislation would reduce health care costs for families by increasing competition across all states through a new health insurance marketplace and eliminating the antitrust exemption. It would reduce costs by promoting coordinated medical care to eliminate duplicative tests, by simplifying insurance paperwork and electronic records. The bill would decrease costs by expanding research on which treatment work best for different patients, helping physicians and nurses provide effective medical care. Long term, the legislation would limit costs by shifting to a focus on health status and rewarding physicians for treating the whole patient.

It would do all this without adding one penny to the debt. Instead, it will lower the debt and, according to the Congressional Budget Office (CBO), produce a $109 billion surplus over a decade. Many of the amendments reflected concerns raised by constituents and have improved this bill further.

We cannot afford not to pass health care reform and reduce the crippling health costs facing our nation, our businesses, and our families.

Sadly, there is a great deal of misinformation about the proposed health reform bill. I have heard from some of the myth that Members of Congress would be exempt from health care reform. It is worth noting that Members of Congress receive their health insurance like any other of the eight million federal employees and we pay premiums just like any other worker. The health insurance reform bill includes several improvements to the overall insurance marketplace, all of which would apply to the federal employee health insurance plans. I welcome the fact that the reform legislation would apply to Members of Congress, just like employees of other large companies.

Opponents of reform also claim that the House health reform bill would encourage euthanasia or insert the government into end-of-life care and limit their options as a citizen. This claim is false. The truth is that the legislation would provide doctors with better payment for talking with their patients. This bi-partisan provision would provide payment for a doctor’s time if a patient chooses to have a conversation about the care that the patient prefers if he or she becomes very ill, but it does not require anyone to use this benefit. These conversations would not involve any government employee, but would be solely between the patient and his or her physician. As noted by the AARP, “[this measure would not] only help patients make the best decisions for themselves but also better ensure that their wishes are followed.”

There is no reasonable basis for concern that seniors’ conversations with their doctors on personal requests for end-of-life care would describe anything other than care which is illegal in New Jersey and 47 other states, or euthanasia, which is illegal in all states. Discussions between the sick or the elderly and their doctors about end-of-life care have long been an accepted part of modern patient care. Further, a survey of patients’ wishes are carried out. In 2003, under the Bush administration, the Agency for Healthcare Research and Quality issued a report outlining a five-part process for physicians to discuss end-of-life care with their patients. Unfortunately, doctors are not paid for such discussions and thus are not encouraged to have them. According to the National Hospice and Palliative Care Organization, which supports this provision, the bill simply would allow for counseling on decisions that require time and consideration.

Another myth is that health reform would provide federal benefits for undocumented aliens. Undocumented immigrants currently may not receive any federal benefits except in specific emergency medical situations. There are no provisions in the House health reform bill that would change this policy. In fact, the legislation explicitly states that federal funds for insurance would not be available to any individual who is not lawfully present in the United States.

I have heard from many constituents concerned about the inclusion or exclusion of family planning services in health insurance reform. The legislation would exclude federal funding of abortion, and maintain existing federal laws protecting conscience rights in health care. In fact, the amendment adopted tonight, which I believe is in error, would go further than existing law and even prevent women from using their personal funds from purchasing coverage for family planning services. I hope the conferees will revisit this issue to ensure women have the freedom to purchase the policies that best serves their needs and conscience.

I am pleased that health reform will help small businesses. According to a report issued from the Council of Economic Advisors in July 2009, the current health care system places a heavy burden on small businesses through high premiums, fixed administrative costs, adverse selection, and comparative disadvantage with larger businesses in America and with businesses in other countries. This is why small businesses pay up to 18 percent more per worker for the same health insurance plan than a large firm. The House legislation would help small business employees purchase insurance at group rates through an insurance exchange and by providing the tools to help small businesses to purchase insurance. Almost 18,000 small businesses in Central New Jersey would receive this tax credit.

The bill further recognizes the constraints facing small businesses and exempts many small employers from the shared responsibility requirement to provide insurance for their employees. The Congressional Budget Office and respected Massachusetts Institute of Technology health care economist Jonathan Gruber have pointed out that for the large majority of small businesses, the reform legislation would be a great improvement and would provide real savings.

For years, small businesses have asked me and other Members of Congress to allow them to get better rates by pooling their employees in large numbers, which is currently available only to larger companies. The expanded marketplace would allow insurance plans to pool the health risks of millions of people and thus get lower rates. In addition to the marketplace for small businesses created by the House health reform bill, I worked with my colleagues Rom ANDREWS (D–NJ) to include language in this legislation that would allow affiliated small businesses to join together to purchase insurance. This proposal for helping small businesses was brought to me by a small businessman in my district.

I also was pleased to write a section of the bill that would create an online job training program for health care workers, modeled after a successful program originating at Rutgers University. This program is needed to help meet the increasing need for health care workers, which was indicated by a July report by the Council on Economic Advisors. The demand for health workers soon will exceed the supply with 48 percent growth in health support occupations such as medical record, clinical laboratory, and health information technicians. My amendment, included in H.R. 3962, would provide new training opportunities to meet this additional demand for health professionals.

While I support the Affordable Health Care for America Act, I look forward to working with my colleagues to improve this bill as the legislative process moves forward. I have heard from home care and hospice providers in my district and across New Jersey who are concerned about the reductions in Medicare home health payments. I have spent time with home care organizations and with individual patients at home and have gained a deep understanding of the challenges and successes that occur each day. I fear that additional cuts to home health would make it harder to do the essential job that home care and hospice services perform. I am concerned that several provisions of the bill may impede biomedical research and innovation, as this research generates patient care
Mr. ANDREWS. I am honored to yield 1 minute to a gentleman who has done an extraordinarily effective job of representing his constituents, the gentleman from the Commonwealth of the Northern Mariana Islands (Mr. SABLAN).

Mr. SABLAN. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act. The need for health care reform has never been greater nor more urgent. This is true for my district, as it is for our nation as a whole.

We must seize the moment and pass a law that will go a long way toward providing quality, accessible, and affordable health care for all Americans.

I urge my colleagues to support the bill.

Mr. KLINE of Minnesota. Mr. Speaker, I would like to yield 2 minutes to another physician, a member of the committee who is not only a doctor, but a small businessman from Tennessee (Dr. ROE).

(Mr. ROE of Tennessee asked and was given permission to revise and extend his remarks.)

Mr. SABLAN. Mr. Speaker, I rise in opposition to this bill before us. I came to Congress to enact health care reform. As a physician, I have seen firsthand the problems insurance companies created for my patients. I have seen insurance programs, increasing everyone's premiums, increasing everyone's out-of-pocket expenses to the private plans, who were forced to make up the underpayments of the government. This bill will not fix these problems; it will make them worse.

The Democrats have ignored evidence that this program won't work. I asked President Obama three separate times since July to sit down and talk about the health care bill and what I know its effects will be, and I have yet to receive a call from the White House. It is one thing to disagree with the evidence that undermines the premise of reform you are pushing, but to not even consider it is unbelievable.

So here we are today with a health care bill that is over 2,000 pages. It is a Christmas tree of special interests. Sewer systems for Indian tribes, biofuel tax credits, nutrition standards for home health care, skilled nursing facilities and Medicare Advantage would all be cut. And seniors with prescription drug coverage will have their premiums increased. Seniors oppose this bill because they get it. Their care is going to decrease and their costs are going up.

The bill spends all that money even after the bill demands Medicaid, despite the fact that I haven't heard anyone who had an option say they want to be on Medicaid. It creates a huge new Federal bureaucracy to navigate through. And it funds a government competitor to private insurance companies that are going to bear the first brunt of the legislation. It is the businesses who are going to help small businesses and reduce their taxes. I think it is no accident to not even consider it.

When I first heard that the Democrats were proposing to insert a government competitor in the insurance marketplace, I thought, surely they can't be serious. When I realized they thought I could agree with evidence that undermines the real-life failures I've seen under our state's program known as TennCare and how H.R. 3200 and now 3962 is simply a bad extension of these mistakes. For months I've gone to the House floor with many of my physician colleagues to talk about the problems with this plan. The TennCare plan tried to provide universal coverage and make health insurance affordable, and in the end it nearly bankrupted the state as the program tripled in cost. It created an incentive for beneficiaries to seek unnecessary care because it cost them nothing. It shifted costs to the private plans, who were forced to make up the underpayments of the government program, increasing everyone's premiums. In the end, 45 percent of those on the plan neither fit your family's needs or not.

Mr. Speaker, I came to Congress to enact health care reform. As a physician, I have seen firsthand the problems insurance companies created for patients. I've seen how the cost of health care has exploded, so much so that many can't afford insurance. I've seen all these problems and I want to fix them.

Our Democratic Governor, Phil Bredesen, saved our state's budget by doing something hard—he cut the rolls. He controlled costs and introduced an alternative plan called Cover Tennessee, which requires an equal contribution from employers, individuals and the government, which is a model for shared responsibility. Incidentally, Governor Bredesen has called this bill on the floor the mother of all unfundable plans.

Democrats continued to ignore this evidence. I asked President Obama three separate times since July to sit down and talk about the health care bill and what I know its effects will be, and I have yet to receive a call from the White House. It's one thing to disagree with evidence that undermines the premise of the reform you're pushing, but to not even consider it is unbelievable.

So here we are today with a health care bill that is over two thousand pages. It's loaded up like a Christmas tree of special interests. It cuts Medicare, despite the fact that I haven't heard anyone who had an option say they want to be on Medicaid. It creates a huge new Federal bureaucracy to navigate through. And it funds a government competitor to private insurance companies that are going to bear the first brunt of the legislation. It is the businesses who are going to help small businesses and reduce their taxes. I think it is no accident to not even consider it.
somehow. Democrats could not come up with a real solution for medical malpractice reform except to try to protect trial lawyers' share of jury awards. Malpractice is proven to cost the health care system billions of dollars every year, but the reforms being proposed make the current system worse. This bill taxes everyone and everything. It taxes medical devices. It taxes individuals who choose not to purchase insurance, and drives up premiums for individuals who do purchase insurance. It taxes employers who fail to offer health insurance, then taxes them further if they then lose some of their employees' wages. It taxes small business owners, who could be creating jobs and getting us out of the recession, and instead forces them to cut jobs or wages. It taxes health savings accounts, which reduces the use of catastrophic health insurance coverage.

It cuts Medicare. Home health care, skilled nursing facilities and Medicare Advantage would all be cut, and seniors with prescription drug coverage will have their premiums increased. Seniors oppose this bill because they get it—their care is going to be decreased and costs are going up.

After the bill finishes up taxing everything and everyone, it spends all that money even faster. The bill dramatically expands Medicaid, despite the fact that I've never heard of anyone saying they want access to the program. It creates a huge new federal bureaucracy to navigate through. And it funds a government contractor to private insurance companies that will siphon people off of private insurance onto a Medicaid-like program, just like Tennessee did with TennCare.

After the Democrats finish spending $1.5 trillion, they say the bill is quote unquote deficit neutral. But they ignore that every major government health care expansion before it—Medicare, Medicaid, SCHIP to name a few—have cost more than originally estimated. And I believe that we as a national government have a responsibility to assist our citizenry in securing quality health care. It is unfortunate that there are those amongst us who just couldn't care less; those who were satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of preexisting conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Mr. Speaker, I urge all of my colleagues to vote for this measure.

Mr. Speaker, today, I rise in support of H.R. 3962, Affordable Healthcare for America Act. This evening we will usher in a new assurance of the health and well being of all Americans. Our children will have the health and peace of mind to exceed the productivity of our generation. Our children, as we approach the dawning of the second decade of the new millennium, we will usher in a new assurance of the health and well being of all Americans. Our children will have the health and peace of mind to exceed the productivity of our generation. Our willingness to do what it takes to transition to a 21st century healthcare delivery system will guarantee future generations the advancement of a productive civil society.

In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance. 15 percent of whom are New Yorkers. Last year alone, New York City's hospitals spent $1.2 billion in charity costs. Tragically, people who are either uninsured or underinsured often have to go without vital healthcare simply because they cannot afford it.

Every American has a right to adequate physical and mental healthcare, and I believe that we as a national government have a responsibility to assist our citizenry in securing quality healthcare. Unfortunately, our Republican colleagues don't seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare system.

It is unfortunate that there are those amongst us who just could care less—those who are satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of pre-existing conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Instead of working with us to fix the problem, they capitalize on people's fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens. Today we will not allow the voices of fear to dominate the healthcare reformation.

This bill provides healthcare coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Healthcare for America Act.

With preventative care as the cornerstone of the 21st century healthcare delivery system, eliminating the disparate treatment of women, eliminating discrimination based on pre-existing conditions, creates a new health exchange for access to quality affordable health insurance and turns medical visits from a broken volume based system to a 21st century value based system. I will cast my vote this evening in memory of a distinguished New Yorker, Florence Anne Woods, who died of heart failure as a young woman in her early 50s.

In my district, the 11th Congressional District of Brooklyn, the Affordable Healthcare for America Act will: First, improve employer based coverage for 367,000 residents. As a result of the insurance reforms in the bill, there will be no co-pays or deductibles for preventative care; no more rate increases or coverage denials for pre-existing conditions, gender, or occupation; and guaranteed oral, vision, and hearing benefits for children. Second, it will provide credits to help pay for coverage for up to 160,000 households, if they need to purchase their own coverage. Third, under the bill's insurance reforms, 11,900 individuals in the district who have pre-existing medical conditions will now be able to purchase affordable coverage. Finally, this bill will allow 11,300 small businesses to obtain affordable healthcare coverage and provide tax credits to help reduce health insurance costs for up to 11,400 small businesses.

Healthcare is a fundamental human right, rather than a commodity. A year ago, Americans cast a historic vote to change the course of this Nation. Today, we cast this historic vote, to finally manifest the change they demanded: Access to Affordable Healthcare. I am proud to cast my vote in favor of this bill.

Mr. KLINE of Minnesota. Mr. Speaker, may I inquire as to the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Minnesota has 16 minutes. The gentleman from New Jersey has 14 minutes.

Mr. KLINE of Minnesota. Thank you, Mr. Speaker.

At this time I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. Thompson), a member of the committee.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I rise today in opposition to H.R. 3962. I came to Congress this past January following 28 years in nonprofit health care. In January, the Democratic majority quickly moved the SCHIP reauthorization. I supported the final passage of the bill. SCHIP was modeled after Pennsylvania's CHIP program, a bipartisan public-private partnership to offer private insurance to my State's most vulnerable population. CHIP works in Pennsylvania.

Mr. Speaker, I am dismayed to learn that this bill will scrap the SCHIP program. This will jeopardize public-private support and increase costs for scores of Pennsylvania's needy children. Families who rely on Pennsylvania's CHIP program will face higher costs when their children are forced into plans offered through the exchange. We have heard from constituents in our seniors, small businesses, family farms, and agriculture. Now you are hearing about the cost to our children.
As a health professional, I urge my colleagues to vote “no” on this measure, and I would like to submit a letter from five of my Republican colleagues from Pennsylvania on this issue.

CONGRESS OF THE UNITED STATES


Hon. NANCY PELOSI,
Speaker, House of Representatives, The Capitol, Washington, DC.

DEAR SPEAKER PELOSI: We are writing to express our grave concerns with provisions included in H.R. 3962, the Affordable Health Care for America Act, that would eliminate the Children’s Health Insurance Program (CHIP) and require all children above 150 percent of the federal poverty level (FPL) who are not covered under a Medicaid CHIP (M–CHIP) expansion program to be moved into the new health insurance exchange. These extremely troubling provisions will add an undue cost burden on children and families in Pennsylvania as well as delays in care and coverage gaps when CHIP plans are terminated.

Members of the Pennsylvania General Assembly strongly advocated for the creation of Pennsylvania’s CHIP law in 1992, and improvements to the program in 1997. Our program served as a model for the federal CHIP law, and it has been an overwhelming success in our state. There is no better example of a public-private health partnership that has contributed to the lives of Pennsylvania families. We are concerned that CHIP families are finding it difficult to cover their children’s health care for the remainder of the fiscal year.

New, only months after you championed for the reauthorization of CHIP, it is surprising that the bill you are ushering through the House is proposing to eliminate this successful program. These provisions would jeopardize coverage and increase costs for scores of Pennsylvania’s children since Pennsylvania operates CHIP as a separate program and makes coverage available to children beyond 150 percent of FPL.

A recent actuarial analysis demonstrates that CHIP benefits are superior for low-income families than the House health care legislation. Families who rely on Pennsylvania’s CHIP program will face higher costs when their children are forced into the plans offered on the exchange. For instance, for children living in families earning 175 percent of FPL, the study finds that the median CHIP plan covers 100 percent of medical expenses, whereas the median plan under the HIX will cover only 45 percent. Under the House bill, that family will pay nearly 400 dollars. For children in families earning 225 percent of FPL the median CHIP plan covers 88 percent of medical expenses, exposing children to only 2 percent of costs. Comparable exchange plans would expose families to only 3 percent of out-of-pocket costs.

We must consider the specific program that provides Pennsylvania children with affordable, quality care. H.R. 3962 is a step in the wrong direction for our children—imposing higher costs and delivering fewer benefits to our most vulnerable population.

For several additional reasons, we will vote against H.R. 3962. Protecting children, especially those most in need, should be one of Congress’s top priorities in the context of health care reform. We urge you to reconsider the direction H.R. 3962 will lead this country and the consequences of eliminating CHIP for Pennsylvania’s children.

Sincerely,

CHARLES W. DENT,
Member of Congress.

TODD RUSSELL PLATTS,
Member of Congress.

BILLY SHUSTER,
Member of Congress.

Mr. ANDREWS. Mr. Speaker, I yield myself 3 minutes.

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

Mr. ANDREWS. I would like to thank my friends on both sides of the aisle. This has been a stressful time for Americans, and today may have been a very stressful day for Americans. This might have been the day that someone thought they were going to get a job but found out that they won’t get the job because they had breast cancer 5 years ago and can’t get health insurance because of their preexisting condition. It has not been their day.

Or it might be the day that a senior citizen decides that they don’t have the money this week to renew their prescription because they’re in the doughnut hole under Medicare. So they’re going to pay their rent instead of their prescription bill, and they’re going to get very sick. It’s just not their day.

Or it might be the day that someone is lying awake in bed, churning about the fact that their child seems a little sicker than usual. But if they take them to the doctor, they might get sent to the hospital, and they can’t pay the hospital bill because they have no health insurance, and it might mean mean bankruptcy or foreclosure or losing their home. It’s just not their day.

If we pass this bill and it gets to the President’s desk, a new day will come to this country, because no person with a preexisting condition will ever suffer discrimination again; because effective next year, eventually no senior will run out of drug coverage at any time during the year because they work for it and they deserve it. The new day will come to that uninsured person because no one here will ever go without health insurance in this country.

You know, the special interests and the lobbyists and the health insurance industry, they have all had their day. They have been around here for a very long time. And I hate to disappoint them, but today is not their day. It is the day for uninsured Americans. It is the day for hardworking Americans. This is the day when we will begin the transition, and we will get the health care they so richly deserve. Stand up for those who cannot be heard, and vote “yes” for this bill.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. EHLERS), a member of the committee.

Mr. EHLERS. Mr. Speaker, I certainly support making health care more affordable and accessible for all Americans. Perhaps I’m naïve, but I have hoped that we would have been able to produce a bipartisan bill that I could gladly vote for. Such is not the case. We were not even given the courtesy by the other party of taking part in writing this bill and presenting ideas which could be included in the bill.

The status quo in the health care system is unacceptable. We must make health care more affordable and accessible than it is. But this bill is even less acceptable than the current health care system. This bill will result in large tax increases, as we’ve heard, which is absolutely the last thing that my State of Michigan needs because we are struggling so hard with the economy the way it is. This proposed bill is basically a government takeover of health care.

What am I looking for? I’m looking for health care quality. That, to me, means getting the treatment you need, when you need it, from the doctor you choose. This bill does nothing to provide that.

Time is a great health care killer among governments. We looked at other countries. They may have very good plans, but if you need an MRI today and you have to wait for 6 months, you are not in good health care.

We want to make sure that the plan we develop provides the health care you need, when you need it, from the doctor you choose.

I truly hope that, in the future, as we go through the process with the Senate, that our Republican ideas will be incorporated as well as the Democratic ideas, and that we really produce the best bill we can. We did that with Medicare. We tried to do it with health care, we want to do it again with Medicare, and hopefully we will produce a bill that participates in the country, works for the people, and especially for those who need medical care.

The SPEAKER pro tempore. Without objection, the gentleman from California (Mr. GEORGE MILLER) will control the remainder of the time.

There was no objection.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentleman from Ohio (Mr. WILSON).

Mr. WILSON of Ohio. Mr. Speaker, as we wind down the clock on the health care debate, I have thought long and hard about what’s best for my district back in Ohio, and I have concluded that the Affordable Health Care for America Act is an important step forward in fixing our broken health care system.

While this legislation is not perfect, there are benefits that are simply too hard to ignore. For example, in my district, 13,000 small businesses will have the opportunity to provide their employees better health care. We will close the drug doughnut hole for over 9,000 seniors just in my district alone, and it will help 174,000 households in the Sixth Congressional District afford better coverage.

I have always promised the people that I work for back home that I will vote in their best interest and that I will stand up for what is right. I am
proud to be here this evening on this issue, and I believe that this bill is the right thing to do to provide stability and security for the families in Ohio in my district.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased to yield 1 minute to my colleague, the gentleman from my home State of Minnesota (Mrs. BACHMANN).

Mrs. BACHMANN. Mr. Speaker, the American people overwhelmingly reject the government takeover of our health care. Last Friday, a couple from Hawaii decided the time is so short they needed to get on a plane, come to Washington to beg their Representative to vote “no” from Hawaii. What sacrifices freedom-loving Americans are making to get their government’s attention and how big our government has gotten.

They brought me this beautiful, precious lei, and I am reminded that the one who created this lei also created our forebears. They were so insensible to the high cost our forebears paid to purchase our freedom? Tonight, would we foolishly bargain those freedoms away? The American people, our forebears, generations yet unborn, are crying out to us to find the strength to preserve their freedoms.

Vote “no” on the government takeover of health care.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentlewoman from Pennsylvania (Mrs. DAHLKEMPER). Mr. Speaker, the American people overwhelmingly have called on us, their Representatives, to enact real change in our country and in their lives. The Affordable Health Care for America Act embodies the positive change the American people have demanded.

This bill creates effective, affordable, and quality reform for all Americans. Seniors will benefit from a stronger Medicare program, no longer subject to the prescription drug doughnut hole or have to pay out of pocket for their primary care needs. Small businesses will no longer be burdened by skyrocketing health care costs. Tax credits and greater competition in the health care market will make coverage affordable for these small businesses, and no individual will ever again be denied health insurance because of preexisting or chronic conditions.

My colleagues, the need for reform is clear, and the time for reform is now. I urge Members on both sides of the aisle to vote for the Affordable Health Care for America Act for our seniors, for all women, for small businesses, and mostly for our precious children and grandchildren.

Mr. KLINE of Minnesota. Mr. Speaker, at this time, I yield 1 minute to the gentleman from Texas (Mr. SMITH), the ranking member of the Judiciary Committee.

Mr. SMITH of Texas. Mr. Speaker, I thank the gentleman from Minnesota, the ranking member of the committee, for yielding me time.

According to CBO estimates, this bill will cost $1.3 trillion and includes $750 billion in new taxes and $500 billion in Medicare cuts. It increases premiums, increases taxes, cuts benefits, and leads to health care rationing. The government, rather than patients and doctors, will make health care decisions. The bill represents a loss of freedom and more government control for the American people.

I support health care reform to help the long-term, low-income uninsured, but it is not here to help us. It is a government takeover of health care. The House Republicans have a better health care bill that lowers premiums for families and small business owners, cuts the deficit by $88 billion, and includes tort reform...

Mr. GEORGE MILLER of California. If I could inquire of the Chair as to how much time is remaining on both sides.

The SPEAKER pro tempore. The gentleman from California has 10 minutes.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentleman from Missouri (Mr. CARNAHAN).

Mr. CARNAHAN. Mr. Speaker, "millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection." President Truman delivered these words in a special message to Congress in 1945, calling for comprehensive health care in America.

Health care in America has been broken far too long, unavailable and unfair for too many, becoming more unaffordable every year. Health care premiums have doubled in 10 years. Health care bills are the number one reason for personal bankruptcies in our country. Health care costs are the number one contributor to our deficit. We spend more on health care than any other country, yet we are near the bottom in terms of health care results.

This bill builds upon the best parts of our private employer-based system and fixes what’s broken to lower costs, increase competition, promote preventive medicine, and protect seniors. Many ideas and concerns from Missourians I represent have been included in this bill to make it even better. History and the American people are calling us to action. The time is now to fix health care in America.

Mr. KLINE of Minnesota. Mr. Speaker, now I yield 1 minute to the gentleman from Alabama (Mr. ADERHOLT).

Mr. ADERHOLT. Mr. Speaker, there is no question we need to address health care problems in this Nation. That is something both Democrats and Republicans both agree on.

However, the government takeover of health care that we are debating tonight adds up to way too much spending, too much government bureaucracy, too many unfair mandates, too much government control in an area with where government just doesn’t belong.

The Republican substitute is about to be debated tonight, and it will attempt to fix the broken aspects of health care, not the whole bill. There will be many of us tonight in this Chamber who will vote “yes” on that Republican substitute because there needs to be changes. However, we will vote “no” on final passage because we don’t want to throw the baby out with the bath water in order to fix the problems.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. SCHAUER).

Mr. SCHAUER. Mr. Speaker, because of rising medical costs, families in America are literally going broke. Yes, broke. The American Journal of Medicine reported that 62 percent of American bankruptcies are linked to medical bills. These medical bankruptcies have increased by 50 percent in just 6 years. The shocking fact is that 78 percent of these people actually had health insurance, but gaps and inadvises in the current system left them unprotected when they were hit by devastating bills.

Important insurance reforms in this bill will fix this, and as a result of this bill, 36,000 of my constituents will finally be able to afford quality health care coverage and peace of mind for their families.

Perhaps more than in any other State, people in Michigan know that the current system is broken. It’s time for us to fix it. It’s time for us to pass H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Indiana (Mr. BURT).

Mr. BURTON of Indiana. I thank the gentleman for yielding.

Government can’t give until it takes. There is no such thing as a free lunch. It can be achieved without an increase in the tax rate that it is.

We face a $1.4 trillion deficit this year alone, and you’re going to add $1.2 trillion to that and a $730 billion tax increase with 10.2 percent unemployment right now. This bill is going to cost about 5.5 million jobs. It’s going to cost $730 billion in new taxes and $1.2 trillion for the program over the next decade. We can’t afford that at this time with unemployment being at the rate that it is.

We face a $1.4 trillion deficit this year alone, and you’re going to add $1.2 trillion to that and a $730 billion tax increase with 10.2 percent unemployment right now. This bill is going to cost about 5.5 million jobs. It’s going to cost $730 billion in new taxes and $1.2 trillion for the program over the next decade. We can’t afford that at this time with unemployment being at the rate that it is.

Mr. OWENS. Mr. Speaker, my district needs one thing: jobs. And then deal with some of these things in a more responsible way.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to our new Member from New York (Mr. OWENS).

Mr. OWENS. Mr. Speaker, my district needs one thing: jobs.

In Upstate New York small businesses are the jobs engine. Over the past 15 years, they have been responsible for nearly two-thirds of all jobs...
November 7, 2009

CONGRESSIONAL RECORD — HOUSE

H12881

created in America. But the cost of health care is grinding the engine down. Over the last decade, small business insurance premiums are up 129 percent. That means much higher expenses, more businesses dropping coverage, more small businesses closing their doors, and enormous pressure on small business owners from competitors overseas and big businesses at home.

The bill can change that. It creates a competitive marketplace where individuals and small businesses can shop for policies at fair rates. It guarantees free preventative care for a healthier, more productive workforce. And it encourages Americans to start businesses of their own because the cost of health care will no longer tie them to the same job.

The people of my district need jobs. They need me to vote “yes.” I came to Congress to move America forward. This bill will do that.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 3 minutes to the distinguished Republican leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

For many of us on both sides of the aisle who believe in the sanctity of human life, the underlying bill allows for taxpayer funding of abortion. The Speaker has allowed Mr. STUPAK and others to offer an amendment tonight.

And, Mr. MILLER, if that amendment were to pass and this bill were to go to conference and there were a vote in the conference on this, would you guarantee me that you would support the House-passed version?

Mr. GEORGE MILLER of California.

Will the gentleman yield?

Mr. BOEHNER. I’m happy to yield.

Mr. GEORGE MILLER of California. As he has already acknowledged, when he was Chair and he went to conference many times, he could not guarantee anything. You will take into this House if that amendment should be passed by this House on that subject, on that amendment. We will take that with the full dignity of that vote into that conference committee.

Mr. BOEHNER. If you can speak for the Senate—nobody else has been able to.

Mr. BOEHNER. Reclaiming my time, the question was this: If the House is to pass the Stupak amendment and this bill is to pass tonight and there is a vote on the amendment, would you guarantee me that you will support the House-passed version?

Mr. GEORGE MILLER of California. I will not guarantee that. You know the nature of the conference committee.

Mr. BOEHNER. Reclaiming my time, this is the third chairman tonight who will provide no guarantees that if the House were to pass the Stupak amendment that they would vote in committee to support the House-passed version.

This is the point of why I’ve been down here making this an issue: just because we pass an amendment to help facilitate the passage of what I think is a bad bill does not mean that the language that this House votes on is committed to by the Democrat leaders in this House.

Mr. GEORGE MILLER of California.

Mr. Speaker, I yield 1 minute to our new Member to the Congress from California, Mr. GARAMENDI.

Mr. GARAMENDI. Mr. Speaker, 3 days ago I had the great honor of joining this august body, which for more than a century has debated health care.

Two hours ago a dear friend Chic Dambach and his adult son came to my office. At the age of 2, Kai’s kidneys failed. Chic and his family had health insurance. Their insurance company refused to cover transplants. Chic and his wife, Kay, were faced with a choice: enormous personal debt or their son’s life. They chose life.

A decade of battles with their insurance company together with crushing debt, Kai, when he becomes 23, will be uninsurable. He has a preexisting condition.

H.R. 3962 is America’s opportunity to end this despicable situation. The bill has strong provisions that reform and creates the penultimate enforcement mechanism: the public option. Americans should not be at risk any longer. The bill deserves our support.

Mr. Speaker, three days ago I had the great honor of joining this august body, which for 220 years has debated the momentous issues of the day, wars, industrial and labor policy, civil rights, environmental protection, and social security, and for more than a century—a health care policy.

Today we are faced with a choice. Do we vote no health insurance reform and continue the current situation that has placed in jeopardy every person in America who is not yet 65 years of age? Or do we vote today to provide every American with a comprehensive, affordable, and available health care policy?

One example of why we must vote yes on H.R. 3962 and end the health care crisis that millions of Americans face each year is Chic Dambach and his son Kai.

Some of you may know Chic as the former President of the Returned Peace Corps Association. Chic and his family had a comprehensive family health insurance policy. At the age of two, Kai’s kidneys failed.

Their insurance company refused coverage for kidney transplants. Chic and his wife Kay were faced with a choice, more than a hundred thousand dollars of personal debt or their son’s life. They chose life.

Today, Kai is a freshman at the University of Maryland. More than a decade of battles with their insurance company has ensued together with a crushing burden of debt. When Kai becomes 23 he will be uninsurable. Like millions of other American’s he has a preexisting condition.

H.R. 3962 is America’s opportunity to end this despicable situation. The bill has strong comprehensive insurance reform and creates the penultimate enforcement mechanism—The public option—that in its fullness would allow all of us to walk away from the clutches of the profit before people private insurance companies whose first operating commandment is “Pay as little as late as possible.”

This must end. Americans should not be at risk any longer. H.R. 3962 is the solution. It deserves our support.

Senator KLINE of Minnesota. Mr. Speaker, I yield for the purpose of making a unanimous consent request to the gentleman from Pennsylvania (Mr. DENT). (Mr. DENT asked and was given permission to revise and extend his remarks.)

Mr. DENT. Mr. Speaker, I rise in opposition to this government takeover bill.

Mr. Speaker, I rise today to ask unanimous consent to revise and extend my remarks and have them submitted to the CONGRESSIONAL RECORD.

I have spent the past week reviewing the 1,990 page health-care bill—H.R. 3962—that was introduced last Thursday and the manager’s amendment that was filed late Tuesday night. I oppose this legislation which will exacerbate rather than solve the problems in our health care system and take our Nation in the wrong direction.

Although I believe health care reform is needed, diminishing Americans’ control over their health care decisions, cutting Medicare benefits for seniors, eliminating SCHIP coverage for low-income children, imposing punitive taxes on small businesses and increasing health care costs for all Americans in order to create an unsustainable entitlement program that will bury our Nation in debt is not the way to do fundamentals. I oppose this legislation.

Mr. Speaker, I rise today to ask unanimous consent to revise and extend my remarks and have them submitted to the CONGRESSIONAL RECORD.

The bill is bad for America because it won’t reduce health care costs—in fact many will see increased costs—and it will cause millions of working Americans to lose their current coverage.

It’s bad for seniors. The bill includes nearly a half-trillion dollars in cuts to Medicare benefits. It will mean less choices, as well as increased premiums and prescription drug costs for thousands of seniors in the 15th District.

It’s bad for Pennsylvania’s children, who will be forced out of the State’s successful CHIP program into plans offered through the health insurance exchange where families will face higher costs.

It’s bad for Pennsylvania’s already struggling budget, forcing an unfunded Medicaid mandate of at least $2.2 billion on our cash-strapped Commonwealth.

It’s bad for small businesses. It will stifle innovation and job creation by imposing punitive surtaxes. It’s bad for the Pennsylvania economy in particular, with a $20 billion tax on the Pennsylvania economy.

It’s bad for Pennsylvania’s already struggling Commonwealth. It will mean less choices, as well as increased premiums and prescription drug costs for thousands of seniors in the 15th District.

It’s bad for Pennsylvania’s children, who will be forced out of the State’s successful CHIP program into plans offered through the health insurance exchange where families will face higher costs.

It’s bad for Pennsylvania’s already struggling budget, forcing an unfunded Medicaid mandate of at least $2.2 billion on our cash-strapped Commonwealth.

It’s bad for small businesses. It will stifle innovation and job creation by imposing punitive surtaxes. It’s bad for the Pennsylvania economy in particular, with a $20 billion tax on the Pennsylvania economy.

It’s bad for Pennsylvania’s already struggling Commonwealth. It will mean less choices, as well as increased premiums and prescription drug costs for thousands of seniors in the 15th District.

It’s bad for Pennsylvania’s children, who will be forced out of the State’s successful CHIP program into plans offered through the health insurance exchange where families will face higher costs.

It’s bad for Pennsylvania’s already struggling budget, forcing an unfunded Medicaid mandate of at least $2.2 billion on our cash-strapped Commonwealth.

It’s bad for small businesses. It will stifle innovation and job creation by imposing punitive surtaxes. It’s bad for the Pennsylvania economy in particular, with a $20 billion tax on the Pennsylvania economy.
trillion dollar program that we will not add a dime to the deficit now or in the future. If we are serious about enacting meaningful health care reform that will ensure that all Americans have access to quality care, we must address the issue of cost. American families and reducing health care costs—health care costs and health care spending is taking up a larger and larger portion of Federal, State, and local governments' budgets.

Regrettably, H.R. 3962 fails to address one of the key reforms that will save billions of dollars and reduce health care costs—medical liability reform. In fact, the provisions in H.R. 3962 will actually heighten the medical liability crisis facing our Nation.

The medical justice system is one of the major drivers of cost in our health care system. Doctors practice defensive medicine—ordering tests and treatments that are not truly needed but prescribed to ward off frivolous lawsuits. We have all been in our doctor's office and thought, “Do I really need this?” This defensive medicine doesn't mean better care; it just means more expensive care. The litigious environment has caused medical liability insurance premiums to skyrocket. In turn, patients pay more for health care because the costs are passed down.

The practice of defensive medicine costs the United States more than $100 billion per year—five times the amount of defense budgets. If we estimate the cost may be as high as $151 billion to $210 billion annually. In Pennsylvania, not only are medical liability insurance rates increasing costs for patients, they are driving qualified doctors out of the Commonwealth.

Recently, the Congressional Budget Office, CBO, released an analysis indicating that medical liability reforms would save the government $54 billion over 10 years and cut national healthcare spending by 0.5 percent a year. These savings would be the result of direct savings from lower premiums for medical liability insurance and also indirect savings from reduced utilization of health care services.

The original House health care bill, H.R. 3200, was silent on medical liability reform. Just 33 of the 2,990 pages of H.R. 3200 addressed the issue. Tragically, the language in H.R. 3962 actually discourages States from adopting effective alternative medical liability reforms. States to adopt effective alternative medical liability laws that will reduce the number of health care lawsuits initiated, reduce the average amount of time taken to resolve lawsuits, and reduce the cost of malpractice insurance.

Specifically, I believe we must stabilize compensation for injured patients, hold parties responsible for their degree of fault, ensure that meritorious claims are swiftly resolved, encourage compliance with accepted clinical practice guidelines, and guarantee that medical care is available to those who need it the most, by providing protections to safety-net providers.

Unfortunately the leadership in the U.S. House of Representatives made the choice to prohibit meaningful reform from being debated on the House floor today. I sincerely regret that the majority decided to bulldoze ahead without considering practical policy that will reduce costs and produce significant savings in our health care system.

With the passage of bipartisan discussion, we can make straightforward reforms to our health care system that will address the most pressing problems. We can enact strong insurance market reforms that provide consumer protections and protect transparency. We can ensure that those with chronic conditions and preexisting conditions have coverage through high-risk pools and reinsurance models. We can actually lower the cost of health care and increase access to affordable coverage by removing restrictive barriers on competition across state lines, allowing businesses to pool together and get the same buying power as their larger competitors, equalizing tax treatment for individuals buying health insurance, and enacting meaningful medical liability reform. We can put our Nation on the path to a healthier future by focusing on prevention and wellness.

Today, the House majority has failed the American people. Now the Senate has an opportunity to prevent this ill-conceived measure from moving forward, and embrace the calls of the American people to unite behind meaningful reforms that will reduce cost and increase access without fundamentally altering the American economy.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Florida (Mr. BILLIRAKIS).

Mr. BILLIRAKIS. Mr. Speaker, I rise today to oppose the Democrats' government takeover of health care.

This bill will raise taxes on individuals and small businesses, cut Medicare for seniors, and raise health care premiums. The bill raises taxes by $730 billion and costs nearly $1.3 trillion. We literally cannot afford this plan.

There is a better way, however. The Republican health care plan is a response to health care reform. It doesn't raise taxes during a recession or cut Medicare. It will lower premiums, making coverage more affordable for families and employers while reducing the deficit by $85 billion. Commonsense ideas like medical liability reform, strengthening association health plans, and allowing people to purchase health insurance across State lines will make health care more affordable without breaking the bank.

The choice is simple. Mr. Speaker, I urge my colleagues to oppose Speaker Pelosi's health care bill and support the Republican alternative.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from Maryland (Ms. EDWARDS).

Ms. EDWARDS of Maryland. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of this historic legislation. It is the most historic in a generation. H.R. 3962 will indeed change the face of health care in this country. This bill really is not about partisanship and it's not about politics, but it is about the American people; and it's time for us to deliver on our promise to them.

As I've listened to my colleagues today talk about why this bill is good for their districts for the uninsured, for men, for women, for our seniors, I'm worried that I may be one of those uninsured. As a young mother, I became so sick that I collapsed in a grocery store, and I was taken to an emergency room. Without health care insurance, I was treated. I was one of those uncompensated. Now it's time for me to pay the American people back with a vote for comprehensive health care reform.

This bill will take the burden off providers and Americans for paying the cost of uncompensated care and safeguards for the health of all Americans. It lowers costs and ends discriminatory insurance industry practices such as denying women coverage for pregnancies or a history of domestic violence.

Mr. Speaker, it's time for us to have the courage to rise above our pecuniary interests.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I'm very pleased to yield 1 minute to my friend and colleague, the gentleman from Ohio (Mr. JORDAN).

Mr. JORDAN of Ohio. I thank the gentleman for yielding.

Mr. Speaker, how bad does it have to get? How bad does it have to get before we stop the out-of-control spending? A $1.4 trillion deficit, a $12 trillion national debt, a trillion dollars in bailouts and stimulus, and now here we come again with $1.3 trillion takeover of our health care system.

One of the things that makes this country so special, one of the things that makes this country the greatest Nation in history is this simple concept, that parents make sacrifices for their children so that when they grow up, they can have life a little better than we did, and then they in turn do it for the next generation, and each generation in this country has done it for one that succeeds them.

And now, unfortunately, what we are doing is borrowing and spending and living for the moment and passing the bill on to our kids. It's wrong and it should stop here.

Vote this bill down. Support the Republican alternative.

Mr. KLINE of Minnesota. Mr. Speaker, can I inquire as to exactly the time remaining for each side?

The SPEAKER pro tempore. The gentleman from Minnesota has 5 minutes remaining, and the gentleman from California has 5 minutes remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I yield at this time to yield 1 minute to the gentleman from Kansas (Mr. MORAN).

Mr. MORAN of Kansas. Mr. Speaker, the Pelosi health care bill creates 111 new bureaucracies and it only cuts one program: Medicare.

I chair the Rural Health Care Coalition. I care about health care especially as it affects rural States, rural
Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. DAVIS).

Mrs. DAVIS of California. Mr. Speaker, as chair of the Consumer Protection and Commerce Committee in the California State Assembly, I worked hard to maintain and improve the protections and the rights that Americans deserve.

In the health care industry, which is really the most important of all sectors that deal with people’s basic needs, millions of consumers are being taken advantage of on a daily basis and have few rights.

This bill changes that. It changes that. It puts it on the track of giving Americans and their families the peace of mind that they will never lose their health coverage.

I look forward to voting on this historic bill which puts consumers and puts America first.

Mr. KLINE of Minnesota. Mr. Speaker, I am very pleased to yield 1 minute to the distinguished gentleman from Oklahoma (Mr. COLE).

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in strong support of this bill, H.R. 3962, the Affordable Health Care for America Act. It is time that we should have been here. We have been trying this for so very long.

You know, if this bill said anything as bad as what I have heard from the Republicans, I wouldn’t support it. But it doesn’t. It’s not said. I don’t know what bill they are reading.

I want to share, though, that I know this will bring relief to my constituents. In my district, there are 35.6 percent of the residents uninsured, and the adjoining district, District 32 of Texas, has about the same number, but we are on different sides for bringing that relief.

The American people have heard so many untruths, they must be confused. Having access, though, a better coverage will show them what the truth is. This bill is a win for all Americans. I stand in strong support of this legislation and urge my colleagues to vote in favor of this historic bill and ask unanimous consent to revise and extend his remarks.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased to yield 1 minute to another physician, the gentleman from Louisiana (Dr. FLEMING).

Mr. FLEMING. It has been mentioned many times during this debate that the AMA and the AARP have endorsed this. However, the polls show that the majority of physicians oppose this. And the polls say that the majority of seniors oppose this bill, the Pelosi health care takeover.

Who is going to be hurt in this? Individually will be required to pay 2.5 percent taxes or go to jail; 5.5 million of them will be unemployed. Businesses will be required to pay 8 percent payroll tax, and the additional excise tax of 5.4 percent, bringing the marginal rate to 45 percent. States will have an increase in unfunded Medicaid mandate. Who is going to pay for that?

Mr. Speaker, seniors will see $500 billion, half a trillion dollars, removed from their access to care.

I urge my colleagues to vote “no” on Pelosi health care.
Mr. GEORGE MILLER of California. I yield to the gentleman from Massachusetts (Mr. OLVER) for the purpose of making a unanimous consent request.

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

Mr. OLVER. Mr. Speaker, I rise in favor of H.R. 3962.

Mr. Speaker, we often hear that America has the best health care system in the world. But, our health care system largely takes care of those who are lucky enough to be able to afford it.

In the past decade, the premiums charged by private health insurance companies have risen more than 75 percent while workers' wages have risen less than 25 percent.

To add insult to injury, the profits of the 10 largest health insurers have risen by 400 percent, and the salaries of their CEO's have tripled.

America now has 50 percent higher health care costs than the highest of the next 20 most industrialized nations.

Yet Americans suffer the highest infant mortality rate among the G-7 countries. Our infant mortality rate is 50 percent above the average for the other 6 countries.

American life expectancies are more than 2 years lower than the average for the other 6 countries.

Clearly, we have the most expensive health care system in the world, but, equally clearly we don't have the best.

We can and must do better. We must reverse these trends.

This is our chance to fix a broken system. I am proud to vote in favor of H.R. 3962, the Affordable Care for America Act.

For the 50 million Americans who still do not have health insurance, this historic legislation guarantees you will have good insurance—in surance that you can afford—which provides a sliding scale of credits available to families that earn up to 400 percent of the federal poverty standard, or $88,200 for a family of 4.

For those of us that are lucky enough to have health insurance, this legislation would provide health care for Americans.

The SPEAKER pro tempore. The gentleman from Minnesota and the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, I yield 1 minute to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, this debate is part of a 97-year-old debate in America. It started with a Republican, Richard Nixon, who, while short on veracity, was great on policy and government. It continued through Bill Clinton, and now we're in a day when we have a chance to accomplish something worthwhile, something Daniel Webster tells us we should do while we are here in our generation and our time, to do something worthy of being remembered.

Theodore Roosevelt said, in this world the only thing supremely worth having is the opportunity, coupled with the capacity, to do well and worthy a piece of work, the doing of which is of vital consequence to the welfare of mankind.

I plan to take my voting card, along with hopefully at least 218 others, and do something that Teddy Roosevelt would see as worthwhile, and provide health care for Americans.

The SPEAKER pro tempore. The gentleman from Minnesota and the gentleman from California each have 1 minute remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, let me just say that what we have before us here is a true loss for American families seeking quality health care and American workers seeking quality jobs. It is remarkable that our colleagues believe 2,000-plus pages of more red tape, more government regulation can lead us to the best trained health care professionals and the most advanced medical devices, far too many Americans do not have access to essential health care. Our current health care system has failed this fundamental fairness principle, and as a result, health care has been rationed in this country with more than 46 million Americans without health insurance.

Long before the November 2008 elections and the beginning of this Congress, there has been near universal agreement that health care reform is necessary, and that the cost of inaction is unacceptable. Today represents an important opportunity to make health care more affordable and more accessible to more Americans.
Comprehensive health care reform involves more than just extending access to the uninsured. The explosion of health care costs has created tremendous challenges for the private sector that has hindered our ability to compete in the global marketplace. Additionally, it is imperative to constrain health care spending that consumes an unsustainable percentage of our federal budget. Health care reform is vital to the nation's economic recovery and fiscal responsibility.

I commend the leadership of the three committee chairmen who have worked tirelessly to craft legislation to repair what is not working well and preserve what is working in our health care system. Thank you, CHARLES RANGEL, HENRY WAXMAN, and GEORGE MILLER for your dedicated efforts to seize this historic opportunity and produce a sensible health care bill that builds upon and improves the employer-provided and private health insurance market.

I am very pleased that the House health care bill (H.R. 3962) includes many essential reforms that will improve health care. The health care systems to ensure that Americans will not be denied coverage due to a pre-existing condition, the requirement for guaranteed issue and renewal, and the limit on out-of-pocket spending are much needed reforms that will make health insurance more affordable. For seniors, I strongly support the funding to close the donut hole in the Medicare Part D prescription drug program.

I am also delighted that H.R. 3962 contains provisions in health disparities, Medicare reimbursement, that have long penalized Minnesota and other high-quality, low-cost states. I greatly appreciate the dedicated work of my colleagues in the Quality Care Coalition (BETTY MCCULLOM, RON KIND, BRUCE BRALEY, JAY INSLEE) to include language that will promote geographic equity. I believe that the requirement for the Secretary of Health and Human Services to implement the recommendations of an Institute of Medicine study will lead to Medicare payment reform that will reward value, not volume. This payment system has the biggest priority because in 2007, Medicare paid Minnesota hospitals $1 billion below the actual cost of care.

While I am very pleased that the House will have the opportunity to vote on amendment to ensure that taxpayer dollars are not spent for abortion, I am disappointed that several important amendments were not made in order. It was expected that the House would consider an amendment that would create a single-payer system for health care. While I continue to have great concerns about a single-payer system, I would support the single-payer amendment. I am disappointed that the Kucinich amendment which was supported in the committee markup to enable states to develop their own innovative state programs was stricken from the bill, and we do not have the opportunity to restore this language.

I am also disappointed, however, that the House health care bill does not contain a number of important policy reforms recommended by the National Rural Health Association (NRHA). The NRHA made more than ten specific recommendations regarding payments that are unjustifiable and would support them in this bill. I am especially troubled that several rural health improvements that were accepted in the committee mark-up were not included in the updated House bill. It is essential that provisions to ensure rural representation on MedPac, and improvements in the 340B Drug Pricing program and the rural health care reimbursement and emergency needs are restored. I am also hopeful that the final conference report will include legislation that Minnesota's Senators and I have authored to provide Critical Access Hospital designation for a hospital in Cass County, Minnesota which I hope the Senate will include in their bill.

I strongly believe that Minnesota's leadership in health care reform should serve as a model for national reform. Minnesota is unique in requiring all health maintenance organizations (HMOs) to be nonprofit as a condition of licensure. Minnesota extends health care coverage to lower-income children long before the enactment of the federal SCHIP program, and Minnesota has done a better job in expanding access to care through its MinnesotaCare program than the rest of the nation. Minnesota's continued endorsement and commitment to meaningful health care reform is far ahead of national policymakers. Even with the expected improvement in Medicare reimbursement that will benefit Minnesota, I am concerned in many respects that Minnesota is picking up the tab to pay for national health reform. While I understand and support the need to reduce the excessive payments in the Medicare Advantage program, it is far easier for high-cost states to absorb a 14 percent cut than for Minnesota which receives significantly less in Medicare Advantage payments. I am also concerned with the addition of a tax on medical devices that will negatively impact Minnesota's important medical device industry, as well as changes in the second generation biofuel producer credit that will prorate “tax-free” eligibility for this biofuel credit that will impact the wood product industry in Minnesota. I will strongly encourage modifications in the financing in the final version to ensure fairness for Minnesota.

During the thorough discussion and debate regarding health care, I have greatly appreciated the opportunity to visit with constituents in Minnesota and in Washington. From seniors and health care providers to organized labor, the small business community and the faith community, I have gained valuable insights and recommendations to improve this legislation.

While I recognize and understand there are many issues that need to be addressed, I am prepared to support this legislation today to move this necessary process forward. Mrs. LOWEY. Mr. Speaker, I rise in support of the Affordable Healthcare for America Act. Over the last eight months, I have communicated with tens of thousands of my constituents in Western and Rockland Counties in meetings, conference calls, round-tables, telephone town halls, and neighborhood office hours.

Among people from all walks of life—small business owners, doctors, patient advocates, and seniors—one constant is the passion which most agree on the need for health care reform despite different opinions on how best to achieve reform. Since 2000, personal premiums have more than doubled. Since 1987, the cost of the average family health insurance policy has risen from 7 percent of the median family income to 17 percent.

In 2007, 60 percent of all U.S. bankruptcies were due to medical costs. The U.S. is on track to spend nearly $33 trillion on health care over the next decade. The financial security of our families, businesses, and our overall economy depends on meaningful health care reform.

That's why I will support this bill today to:

Provide health coverage to approximately 36 million Americans, including 39,000 residents in my congressional district.

Help small businesses who are struggling to provide coverage to their employees while exempting 86 percent of the smallest businesses from the requirement to do so.

Ensure that reform is fully paid for while exempting 99.7 percent of all American households from paying a health care surcharge.

Guarantee additional protections to those who have insurance, including ending discrimination for pre-existing conditions; limiting annual out-of-pocket costs; and preventing health insurance companies from dropping your coverage if you become sick.

Improve and strengthen Medicare.

Now, this bill is not perfect. I am deeply disappointed that the House approved language which puts new restrictions on women's access to abortion coverage in the private health insurance market even when they would pay premiums with their own money.

If we want to reduce abortions we should give millions of women health care so they can get regular reproductive care, contraceptives to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.

Despite this damaging provision, we must move forward in improving health care coverage for those who have it, providing coverage for those who don't, and controlling costs throughout the system.

I urge my colleagues to support this legislation.

Mr. LOEBSACK. Mr. Speaker, this August and September I held 16 town halls across the 2nd District of Iowa. I heard from countless Iowans about the need to change the current health care system. Though some disagreed with provisions in the original House proposal, almost everyone agreed that the fact that a family in Iowa pays an extra $1,100 per year in premiums to support a broken system was unacceptable. So I am proud to be a part of a Congress that decided the status quo is no longer acceptable. I want stable health care coverage that can't be taken away, they want greater choices, and they want to know that if they get sick they won't be forced into bankruptcy. The Affordable Health Care for America Act answers these calls to action and I am proud to support a bill that is good for Iowans.

This legislation keeps what works in the current system and fixes what doesn't. If you like your current health insurance and you like your doctors you can keep them. If you don’t have health insurance, you will be able to access the greatest changes from the original House proposal to the bill we are considering today are the immediate reforms. We aren't saying wait for coverage, we
are saying the status quo is not fair and we will no longer tolerate it starting right now.

There will be help for hardworking families now. The revised bill immediately creates an insurance program with financial assistance for those who have been uninsured or denied coverage. The provision creates a safety net for the uninsured, fills the gap until the Health Insurance Exchange is up and running. The bill immediately prohibits health insurance companies from rescinding coverage. If you find out you are sick one day, you don’t have to worry that your health insurance will be taken away the next. The bill also immediately prohibits health insurers from utilizing lifetime limits on benefits, and extends COBRA eligibility to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running. America’s Affordable Health Care for America Act also makes immediate changes to improve the health and well being of our seniors. The legislation begins closing the Medicare Part D Donut Hole in January. There will also be an immediate 50 percent discount for brand name drugs in the donut hole.

In addition to the immediate benefits, this legislation takes a comprehensive approach to long-term reform. I am a native Iowa, and since I came to Congress I have been committed to fixing the broken Medicare payment system. With some of the lowest reimbursement rates in the country, they provide some of the highest quality care. However, the current system is broken and now I’m proud to say that the Affordable Health Care for America Act reforms Medicare payments so that they are based on the quality of services rather than the quantity of services. This fix benefits not just Iowa, but all of America.

I also want to mention another provision with direct benefit to Iowa in this legislation. According to a 2008 Institute of Medicine report, Iowa is a leader for an Aging America. Building the Health Care Workforce, in the near future, the nation will be aging dramatically, leading to an increase of older adults from 12 percent of the U.S. population in 2005 to almost 20 percent by 2030. As the population ages, their health care needs will increase, and they will need additional supports. In the same report, it’s stated that meeting the demand that is expected in coming years will require expansion of the roles of many members of the health care workforce, including technicians, direct-care workers, and informal caregivers, all of whom already play significant roles in the care of older adults.

I was very pleased to have language included in this bill that takes much needed steps towards making these workforce demands as well as other projected long-term health needs. The provision encourages the identification, promotion, and implementation of investments in the long-term care workforce and assists States in developing comprehensive state workforce development plans. It also establishes a Workforce Advisory Panel which will identify core competencies for long-term care workers and recommends training curricula and resources for these workers. The bill also creates a demonstration project to evaluate the Panel’s recommendations. In addition, this legislation improves assistance to family and informal caregivers, and improves the dissemination of information to seniors regarding their long-term care health insurance options.

In a recent guest column in the Des Moines Register, John Hale from the Iowa Caregivers Association, highlighted the efforts that Iowa has already undertaken on long-term care workforce shortages and spoke about the national need to address these issues. Mr. Hale stated: “The current system does not equal access to care.” I could not agree more. Federal support is essential in helping all states continue to look at both workforce shortages and the core competencies that should be required of those in the field. I have said many times in the past weeks and months that quality health care is the key to patient outcomes. I am glad this legislation takes much needed steps to support our long-term care workforce.

There are many more important provisions in this legislation and in the coming days, weeks, and months I look forward to discussing this bill, and what it does for Iowans, with my constituents. I look forward to voting for the Affordable Health Care for America Act, and abolishing the status quo.

Mr. WESSELHORN, Mr. Speaker, on this bill the Congress is scheduled to vote on today will cost more than $1.3 trillion over the life of the bill.

It’ll expand entitlement spending, it’ll raise taxes on small business payrolls, it’ll cost jobs by mandating coverage that some businesses can’t afford, it’ll put government in between the doctor and the patient, and it’ll cut Medicare funding. By expanding Medicaid eligibility, the legislation puts new burdens on states that already are struggling to pay their bills. The states share the cost of the Medicaid program, and this could cost my home state $2 billion to $4 billion over the next 10 years. That’s a huge share of Georgia’s state budget, and it’s a cost we simply can’t bear.

But, luckily, there is a better way. Republican members of Congress, although the Democrats continue to insist we’re not offering ideas. We are. They just don’t want Americans to know it.

Ms. SPEIER. Mr. Speaker, today, I look forward to keeping my promise to the voters and taxpayers who sent me to Congress by casting a vote for a historic health care reform bill that has been sixty years in the making. Still, with any effort as far-reaching as re-forming health care, Americans are right to ask: "What’s in it for me?"

Well, I’ll tell you. If you are a woman, this bill has plenty for you. You know, far too well, that our fight for equality is not limited to the boardroom. We must fight for our rights in every line of fine print in every insurance contract. The fact is that women’s health care premiums cost, on average, more than 145 percent of the price of a similar man’s policy. Even then, women are more likely to be denied coverage for a pre-existing condition, including for things as common as getting pregnant (or the inability to get pregnant) having a c-section, even being a survivor of domestic violence. With the passage of this health care reform bill, these practices will be tossed on the ash-heap of history atop corsets, chastity belts and other limitation on women’s rights and equality. In fact, with this bill, America’s mothers, wives and sisters will finally enjoy the same health care coverage that their fathers, sons and brothers have.

If you are an American of retirement age, this health care reform legislation contains provisions that ensure high quality, effective health care throughout your retirement years. We have heard your frustrated calls to end the ill-conceived Medicare Part D donut hole and I’m proud to say that the bill is projected to cover the donut hole by $500 and, by 2019, getting rid of it once and for all. The bill also cuts in half the cost of name-brand drugs. No older American should ever have to decide between purchasing food or the life-saving medicine prescribed by their doctor.

When Congress voted for Medicare nearly 45 years ago, this House promised seniors quality, affordable health care in their retirement. They did this despite a future president, Ronald Reagan, decrying Medicare as socialism.

Well, by cutting waste, fraud and abuse, eliminating the out-of-pocket payments for preventative care and banning overpayments, this Congress is making good on that promise and extending the Medicare trust for future generations.

If you are one of the 14,000 Americans who lose their health insurance coverage every day, this bill offers comfort and hope when you are most in need. Just last night during a telephone town hall a constituent told me how, at 55 years old, she lost her job and her health coverage. She wonders if, even after the economy recovers, she will be able to get a job—at her age—that provides health care. Today, when workers like her lose their job and their coverage, they are forced into the snake pit that is the individual insurance market where insurance company practices like denying coverage because of a preexisting condition are common. Fortunately this practice, along with dropping customers once they fall ill, has been outlawed in this bill. Also, while the health care exchange—which will provide access to affordable, quality health care—is being set up, a high-risk insurance pool will be available so that you have coverage in the meantime. For the majority of Americans who have health insurance through their employer, you get the best news of all. I don’t have to tell you that, since 2000, employer-sponsored health insurance premiums have more than doubled. Your employer’s real health care costs have risen at a rate that is three times faster than wage increases and business profits. This is, quite simply, unsustainable. If we took a page from the opposition party and did nothing, the cost of employer-sponsored family health insurance plans could be $4,000 in less than ten years. This same price spike would result in families spending 45% of their income on health insurance. Also, the insurance exchange will allow you or your employer to purchase coverage from health plans that meet guaranteed benefit levels, capped annual out-of-pocket spending and end annual and lifetime benefit limits. There will also be a public option that is completely self-supported by premiums.

This is not a decision that has been made in haste. No issue has been studied, scrutinized and debated more than health care reform. And, like every time in our nation’s history when sweeping changes are proposed—
whether it be Social Security, Medicare, civil rights, women's suffrage or the creation of the Veterans Administration—emotions have run high in this debate and there has been no shortage of opinions on every side.

The bill we are set to vote on is a compromise between two very different points of view. It is the result of the most exhaustive and transparent review process of any bill in our nation's history, with hundreds of hours of bipartisan committee meetings being devoted to it and the final text being posted on-line more than three days prior to a vote being taken. And, as the Republicans have pointed out, the Senate bill Part D bill in 2003 which was forced to a vote just hours after the bill was printed. It will be a proud day for this Congresswoman—and for America—when Congress finally sets our nation on a path toward greater access, greater equality and greater accountability and competition in our health care system.

This is what my constituents sent me here to do. And I am happy to oblige.

Mr. Speaker, even today, everyone agrees that health care costs too much in this country, but we can fix the problem without a trillion-dollar government takeover of health care. The bill before us now takes us in the wrong direction. It slashes Medicare and pins small businesses with job-killing taxes and mandates when our economy is struggling and unemployment is over 10 percent.

More federal controls on the content of insurance policies have nothing to do with covering the uninsured and will increase costs for most families rather than decrease them. If you have coverage through an employer, your premiums will go up. If you have an individual policy, you will have to switch to a federal exchange plan in 2013 or face a fine or, possibly, jail time for not having federally qualifying coverage that you may not be able to afford. Younger people in particular could see their premiums increase by more than 70 percent.

Instead of taking the approach we are taking today, we should implement commonsense reforms that focus on covering the uninsured and lowering health care costs. We must ensure those with pre-existing conditions get quality coverage. We can lower costs by requiring insurance companies to compete nationwide, and we can clamp down on frivolous malpractice lawsuits. Most of the uninsured work for small businesses that cannot afford health insurance for their employees, and we should allow small businesses to pool together for lower premiums. Such reforms have bipartisan support and could be enacted immediately to provide relief for millions of Americans struggling with health care costs.

On another note, this bill contains no guarantee that Iowa's Medicare reimbursement rates—which are among the lowest in the country—will see any sort of increase. At the same time, this bill significantly increases Medicare payments in 14 counties in California, the home state of Rep. Henry Waxman, one of this bill's main authors. This may be viewed as reform by some, but it is certainly uneven reform for those counties in our districts that do not benefit from such increases.

Throughout the summer and early fall, more than 12,400 residents of Iowa's 4th Congressional District responded to my health care survey. A majority were unsatisfied with the state of health care in America, and rightly so. More than 70 percent of respondents ranked cost as the most pressing concern regarding health care in the United States, followed by access at 14.6 percent and quality at 8.4 percent. However, 86 percent described the quality of their health care as either "excellent" or "good" and they do not want to be forced to give up coverage they are satisfied with. Some 65 percent said the government should play "no role" or a "minor role" in determining health insurance options for Americans. My constituents support common sense solutions and would rather see the government stay away with exclusions for preexisting conditions, 75 percent thought people should be allowed to purchase health insurance across state lines, and 69 percent support small business health plans.

To sum it all up, this bill is clearly not what is advertised by its supporters and it is not what my constituents want. We need to go back to the drawing board and produce a bill with common-sense solutions that the vast majority of Americans support.

Mr. Speaker, I have spent 20 years caring for the uninsured in Louisiana's public hospital system.

Skyrocketing costs put quality care out of reach for too many Americans, and I appreciate that everyone agrees the status quo is unacceptable. All agree on the goals of reform: lower costs and expand access to quality care.

Unfortunately, this bill does not achieve our goals.

The Congressional Budget Office says it raises costs. Without lowering costs, access or quality will suffer. Its effects will be radical, but this is not a radical bill. It turns insurance bureaucrats into federal bureaucrats.

There's no innovation, just nationalization. Real reform would revolutionize health care. Real reform would give patients, not bureaucrats, the power. Unless patients are empowered with control over their health care dollars and decisions, costs will not be lowered and access will not be expanded without sacrificing quality.

The road to real health reform begins with stopping this bill today.

I urge my colleagues to join me in this effort.

Mr. PRICE of North Carolina. Mr. Speaker, as the House of Representatives approaches this historic vote, my mind travels back to the formative years when I first became engaged in politics, and also to hundreds of meetings I have had with constituents since the citizenry of North Carolina's Fourth district first sent me to Congress.

I came of age as the civil rights movement of the late '50s and early '60s swept across the country. It shaped and transformed my social, religious, and political views. I remember the calming moment in 1964 when, as a Senate staff member, I crowded into the gallery and witnessed the dramatic passage of the Civil Rights Act of 1964.

That momentous bill marked an expansion of democracy and of authentic opportunity for millions of Americans. Today's vote is also momentous, and it also marks an expansion of democracy's promise. Today we resolve that never again will American citizens be denied access to health insurance, and that one of life's most basic needs—health care—will be available to all of our people.

As I think back on my years of congressional service, I remember meetings with parents terrified at the prospect that their children with rare illnesses would not be able to obtain coverage when they reach adulthood. I remember maddening stories of families coping with illness while simultaneously fighting with insurance companies. I remember young adults unable to buy affordable insurance, often because of allergies or other minor conditions. I remember retirees not yet eligible for Medicare being quoted rates of thousands per month because of their health history.

Mr. Speaker, we have all heard these stories. They are not worthy of our country. And today we have the opportunity to bring such hardship and heartache to an end. The American people deserve a health care system that works for them—one that provides access to stable coverage, quality care, and affordable premiums and copayments. The legislation before us today will undo the failures of the American health care system without compromising its many strengths or adding to the budget deficit.

If you have coverage at work, you'll be able to keep it—but the cost of a job will no longer mean the loss of affordable coverage. And your insurance company will no longer be able to impose lifetime benefit limits; discriminate on the basis of age, gender, or pre-existing conditions; or cancel your policy if you get sick.

If you have coverage through Medicare, you'll have more benefits and lower out-of-pocket costs, including no more copayments for preventive and many diagnostic services, and a 50 percent discount on your brand-name prescriptions, and a progressive closing of the gap in coverage known as the "doughnut hole."

If you don't have coverage at all, you'll be able to buy it on the National Health Exchange at the same affordable group rates that big companies have always been able to negotiate for their employees. And you'll have more than one choice, so that companies will have to compete for your business instead of the other way around.

Landmark reforms—Social Security, Medicare, Medicaid—these things do not come easily. We were sent to Congress this year to do what is difficult. Despite the efforts of some shrill voices, we are on the verge of overcoming the special interests that halted reform more than a decade ago, to deliver on landmark legislation that will make a positive difference in the life of every American. It is a historical moment, an essential investment in our nation's long-term fiscal and economic well-being, and it's long overdue. I urge my colleagues to vote yes on the Affordable Health Care for America Act.

Mr. BACA. Mr. Speaker, today is a historic day for all of us. As Members of Congress, it is our duty to pass real healthcare reform this year. The American people want action. 47 million people lack even the most basic care, and for those lucky to have insurance—their premiums have more than doubled over the last 10 years.

Perhaps no state is in greater need of this reform than my home state of California. 217 thousand people in my Congressional District go everyday without insurance.
And for California as a whole—we have 13 million uninsured residents. The people of California, and people across the United States need health care reform that: ends discrimination based on pre-existing conditions; ends dropped healthcare coverage because they get sick; ends co-pays for preventative care; and ends skyrocketing costs for individuals and families. The Republican alternative does none of these things. It simply keeps the status quo! It does nothing to improve quality, affordable healthcare to the American people.

The 217,000 people living in my District without insurance cannot afford inaction any longer. The 13 million people in California without insurance cannot live with the status quo. The 15 hundred families in my District who went bankrupt because of health costs cannot afford the status quo.

Now is our opportunity to make history—and to move America forward.

We must not be short-sighted and focus only on politics and polls. As a Christian—my faith teaches me we must love and care for our fellow man, as if they were our brother or sister. I know that fixing our broken health care system is not just an economic issue—it is also a humanitarian and a moral issue.

I am especially pleased that today’s bill includes the Indian Health Care Improvement Act. As a Member of the House Native American Caucus and the Natural Resources Committee—I have been a strong supporter of ending the health disparities that exist on our reservations. I will close my statement by again stressing the importance of this historic moment.

We passed Social Security in 1935. We passed Medicare in 1965. I urge my colleagues to stand with the American people and pass legislation in 2009 that will make quality, affordable health care a right for all Americans.

Mr. LANCE. Mr. Speaker, this evening members of the U.S. House of Representatives are being asked to vote on legislation that dramatically revamps our Nation’s health care system.

This 2,000-plus page, $1.3 trillion Democratic health care proposal is a measure that raises individual and business taxes and reduces funding for Medicare.

H.R. 3962 increases spending by more than $1 trillion at a time when our levels of debt and deficits are at all-time highs.

The bill imposes a 5.4 percent “surtax” on thousands of individuals and families in my congressional district during an economic recession when New Jerseyans are paying some of the highest federal, state and local property taxes in the country.

The health care bill levies at 2.5 percent tax on the Garden State’s medical device industry that employs more than 300,000 in New Jersey alone. New Jersey’s unemployment rate is nearly 10 percent.

The measure ignores common-sense malpractice reforms while cutting Medicare by nearly $500 billion leading the Medical Society of New Jersey and its doctors and medical professionals to come out in opposition to H.R. 3962.

In short, this bill, if signed into law, will be harmful to New Jersey’s taxpayers, seniors and businesses. As such, I rise in strong opposition to this measure.

But make no mistake—I support health care reform. Like the majority of my colleagues I strongly support health care reform. But not the reform we will be voting on this evening.

I stand in support of common sense steps to broaden health care access and responsible solutions that address the rising cost of health care.

I believe reform ought to include portability—allowing people to keep their health insurance whether they change jobs or move to a different state. And no one should be denied coverage for pre-existing conditions.

Yet the call for common sense health care reform should be one that our Nation can afford.

The Republican substitute offered by House Republican Leader JOHN BOEHEIMER is a fiscally responsible alternative health care reform measure that reduces costs and expands insurance coverage without raising taxes, rationing care or putting the government between patient and doctor.

The Republican reform bill includes medical liability reform that will seek to end junk lawsuits that force doctors to practice defensive medicine driving up health care costs.

The GOP alternative will allow families and businesses buy health insurance across state lines while also allowing individuals, small businesses and trade associations to pool together and purchase health insurance at lower prices.

It levies no taxes on New Jersey’s medical device industry and includes important safety provisions concerning innovative biologic drugs by requiring research and clinical trials before the Food and Drug Administration can approve generic biologics.

To maximize safety, I believe that research and those clinical trials should be conducted within the United States. By creating this process for approval of innovative biologic drugs we protect the health and safety of patients, lower health care costs and provide adequate incentives for innovation to ensure that New Jersey continues to be the “Medicine Chest of the World.”

These are ideas that have strong, bipartisan support but most are absent from the Democrats’ new reform legislation.

Instead of focusing on fiscally responsible reforms that have bipartisan support, the Democratic Leadership has chosen a path that ignores good ideas from the Republican side of the aisle.

The Republican substitute is the only health care reform measure that improves what is working in our health care system and fixes what is broken in a fiscally responsible manner without raising taxes or increasing our ever-growing debt and deficit.

Mr. WILSON of South Carolina. Mr. Speaker, I have criticized many of the provisions of this bill (H.R. 3962) and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were included in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I believe we should remove from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to get to these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a long-standing success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2 percent it is critical that we preserve jobs in the United States. While the innovator’s have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can should be conducted within the United States. This research and testing of whether or not they can be safely and effectively. These tests will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a long-standing success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2 percent it is critical that we preserve jobs.

Testing and research on these interchangeable biosimilars should occur in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. SMITH of Texas. Mr. Speaker, although the Democratic Leadership has had several months to address the concerns voiced by countless Americans, the latest health care reform bill is no better than the last.

Support health care reform. But make no mistake—I support health care reform. Skyrocketing costs have crept into our health care system, creating uncertainty about the future of health care for employers, working Americans, and the uninsured. Americans need more, not fewer, choices for something as important and personal as health care.

Americans are concerned with cost, choice, quality and access to care. Congress should work to address these concerns. Any legislation considered should attempt to make our health care system more account-

able and accessible to patients.

This legislation expands coverage and allows the market takeover of the health care industry funded by new taxes and massive cuts to Medicare.

The nonpartisan Congressional Budget Of-

fice and Joint Committee on Taxation estimate that H.R. 3962 would require over $550 billion in new taxes on individuals and small businesses.

CBO also estimates that this legislation will lead to $33 billion in penalties for uninsured
individuals and $135 billion in penalties for employers under the government mandate or “pay or play” requirements.

Raising income taxes on hard-working Americans and threatening small businesses with penalties to fund a government takeover of health care is a terrible prescription for a troubled economy.

In order to pay for this government takeover of health care, Democrats also have proposed cutting more than $500 billion in Medicare spending. The plan also includes an expansion of the Medicare program that will cost cash-strapped States $34 billion over the next 10 years.

I believe Congress should pursue reform in terms of costs and access, but the legislation advanced by Democratic leaders is equal parts faulty premise and flawed logic. Their legislation will increase health care spending, limit choice, and cut Medicare benefits.

The current health care proposal being considered by Congress will lead to higher costs, rationing of care, higher taxes on families and small businesses, elimination of jobs through punitive taxes on small businesses, granting of unchecked power to a new “health care choices commissioner,” elimination of choices for patients, tax-payer funded abortions and a government panel placed between doctors and patients.

Americans deserve the freedom to choose the type of health care that is best for them and their families.

During his campaign, then-Senator Obama promised that he would “have all the negotiations around a big table” and “televised on C-SPAN” to “allow people to stay involved in this process.” Yet the negotiations and decisionmaking process have taken place behind closed doors with the media and American people shut out.

That is why the bill lacks bipartisan support. In fact, there is bipartisan opposition to the House Democrats’ government take-over.

Rather than increasing taxes and rationing care, the President needs to address medical liability reform, which is one of the biggest sources of waste and added cost.

Frivolous lawsuits force physicians to practice defensive medicine and carry expensive medical liability insurance, the cost of which is passed on to patients. Uncapped lawsuit awards paid by insurance companies also get passed on to patients as higher premiums.

It is a disservice to the American people that this legislation fails to include the legal reforms that are necessary to make any expansion of health care coverage financially sound.

Unlimited lawsuits enrich trial lawyers while increasing the cost of health care for everyone. Unfortunately, we now know that opposition to the reason tort reform has been excluded from all the Democrats’ health care proposals, including the one we will be voting on today. Former Democratic National Committee Chairman Howard Dean said the following publicly at a recent town hall meeting: “[T]he reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers . . . and that is the plain and simple truth.”

That political opposition, which Governor Dean admitted is not based on the merits but on raw self-interest, flies in the face of the facts.

The CBO estimates that enacting tort reforms nationwide would result in a reduction of medical malpractice insurance rates by 25 percent to 30 percent. And according to the Government Accountability Office, rising litigation awards are responsible for skyrocketing medical professional liability premiums.

Lower premiums mean Americans will pay less to have better health care.

The President’s own medical association said “if the [health care] bill doesn’t have medical liability reform in it, then we don’t see how it is going to be successful in controlling costs.”

And the President’s own doctor of over two decades supports tort reform. He said recently, fully, that “I once briefly talked to [the President] about malpractice, and he took the lawyers’ position.”

In the handful of States that have enacted tort reform, health care costs have fallen, and the availability of medical care has expanded. In my home State of Texas, premiums fell by 30 percent, and more than 14,000 doctors returned or set up new practices in the state.

To give just one example, a charitable hospital group in Texas that serves the poor and uninsured Texans reported that since Texas enacted tort reform, its legal costs have gone from $153 million per year to just $2.3 million last year.

Doctors are so concerned about frivolous lawsuits that they order unnecessary—and expensive—tests and procedures that are of no benefit to the patient.

HHS estimates the national cost of defensive medicine is more than $60 billion. The Congressional Budget Office just issued a report that concludes it costs $54 billion. The costs of litigation and defensive medicine are then passed off to the patient in the price of health care.

If tort reform were enacted, trial lawyers would stand to lose one of their primary sources of income: medical malpractice suits, which are often just a form of legalized extortion. But all Americans would gain, and tens of billions of dollars would suddenly be freed up and could be used to help provide health insurance to the uninsured.

Regrettably, the Democrats’ health care bill not only fails to contain any of the tort reforms the CBO concluded would save at least $54 billion in health care costs, but also contains a provision that bribes States with federal taxpayer dollars not to enact such reforms in the future. It explicitly prohibits tort reform “demonstration project” funds from going to States that put limits on damages or attorneys’ fees.

Section 2531 of the Democrats’ bill states that “the Secretary [of HHS] shall make an incentive payment . . . to each State that has an alternative medical liability law in compliance with this section,” but then goes on to say that such funding will be capped at “only if the law does not limit attorneys” fees or impose caps on damages,” which are exactly the tort reforms the CBO concluded yield real health care costs savings.

That is not only a blow to State reform efforts. It is a federally funded bribe discouraging states from enacting real reform and a giant bailout for trial lawyers.

H.R. 3962 also contains two antitrust provisions that are within the House Judiciary Committee’s jurisdiction: Sec. 262, which repeals the McCarran-Ferguson Act for health and medical liability insurers, and Sec. 2573, which codifies a ban on settlements between name brand and generic pharmaceutical manufacturers in the context of Hatch-Waxman litigation. Neither provision was given due consideration in the Judiciary Committee, and their unintended consequences could have significant negative impacts on the cost and availability of both insurance and medications.

My basic concerns with Sec. 262 are its bipartisan opposition, the possible unintended consequences, and the fact that the provision will do no good and may do much harm. For more than 60 years, the States have regulated the business of insurance and built a record that provides guidance about permissible activity. By inviting Federal intervention, this bill creates additional regulations that confuses the health insurance and medical malpractice industry.

The bill presents a wholesale repeal of McCarran-Ferguson for health insurers and medical malpractice insurers. Further, the protections for information gathering by a State insurance commission or other State regulatory entity that were included in the similar bill (H.R. 3596) reported by the Judiciary Committee over my opposition have been completely eliminated from the legislation. Uncertainty created by this provision threatens small and large insurers alike, but the smaller ones that depend on sharing information, under oversight by State regulators, are most at risk. Thus the bill threatens to reduce competition among health and medical malpractice insurers. With demonstrable benefits and many potential adverse effects, Sec. 262 should not have been included in the bill.

Section 2573 raises different concerns. When a generic drug manufacturer files an Abbreviated New Drug Application under the Hatch-Waxman Act with the Food and Drug Administration, it indicates its intention to infringe on a brand manufacturer’s patent. This means that the generic company is trying to enter into the brand manufacturer’s drug market before the branded pharmaceutical’s existing patent has expired. This notice usually results in a lawsuit by the brand company that leads to a settlement about the date on which the generic manufacturer can begin selling a generic version of the branded company’s drug. This is nothing new. Most cases in the United States, whether civil or criminal, anti-trust or patent, settle. The reasons for this are simple: litigation is expensive and its outcomes are uncertain.

The supposed problem is when a settlement in the Hatch-Waxman context involves a payment in lieu of or in addition to an agreement on the date of entry into the market by the generic manufacturer. Such payments are said to frustrate the intent of Hatch-Waxman by allowing the brand company to “pay to delay” entry of the generic.

The proposed solution to this problem, incorporated in Sec. 2573, goes too far. The bill calls for a ban on all Hatch-Waxman settlements that feature any consideration, such as cash or an exchange of patents, in addition to the date of entry. Such a ban dramatically reduces the ability of companies to settle these cases. After all, if the parties could not agree on date of entry, then they would effectively be forced to litigate the case to the bitter end. This means that, in some cases, a settlement would have resulted in generic entry into that particular drug market much earlier than if the brand company wins its patent suit.

I fear this ban will itself frustrate the intent of Hatch-Waxman by limiting the incentives for
generics to challenge these patents and for brand companies to innovate. The best way to reach the appropriate balance is through a case-by-case analysis by a neutral third party of the competitive effects of these patents on the pharmaceutical industry.

The only saving grace of Sec. 2573 is that it creates an action separate and apart from the antitrust laws and will not affect how those laws are interpreted in the future. This also means that the provision, as written, did not come before the Judiciary Committee, even though it remains, at heart, a competition issue. By keeping the Judiciary Committee from considering this legislation, we are eliminating the incentives for drug invention and generic competition that have served American consumers so well. Innovative new drugs, after all, are created in the laboratory, not the courtroom.

Sec. 1640 of the bill also contains a provision that allows the Department of Health and Human Services to issue administrative subpoenas to insurance companies during investigations of decisions to exclude benefits. The standard for issuing an administrative subpoena is not as strict as at the federal level. This reform sought must simply “relate to” the matter under investigation.

It is highly ironic that we are considering this bill with this administrative subpoena language during the same week the Judiciary Committee approved a Democratic revision of the FBI’s authority to issue National Security Letters, which are the functional equivalent of administrative subpoenas used in foreign intelligence and terrorism investigations.

The Democrats’ bill reported this week by the Judiciary Committee replaces the current “relevance” standard for issuing a National Security Letter with a heightened standard, requiring the FBI to show “specific and articulable facts” in order to seek particular information using a National Security Letter. House Democrats want to make it easier for the government to investigate insurance companies than to investigate terrorists plotting to kill Americans.

In the end, this 1,990-page bill will raise premiums and health care costs on all Americans. It imposes mandates and new taxes on the middle class and small businesses. It fails to address tort reform and it dumps a huge unfunded expansion of Medicaid on the states. Combined with budget gimmicks to hide $245 billion in costs and massive cuts to senior benefits in Medicare and Medicaid, this bill will be harmful to Kansas and I strongly oppose it. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to patients without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted in a bipartisan vote for the Eshoo-Inslee-Barton, EIB amendment in the House Energy and Commerce Committee.

Creating a pathway for new products that does not destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time, provides a market to bring competition to benefit patients and encourage treatments, is a necessary objective. New biosimilars have the potential to fundamentally change the course of many diseases. We need to promote patient safety and ensure incentives to encourage the continued development of a critical weapon to fight diseases such as Alzheimer’s, Parkinson’s and cancer. I wish we could remove these specific provisions from H.R. 3962 and consider them separately because it would most likely pass with the kind of overwhelming bipartisan support.

However, these provisions are only the first step in a long path to the marketing of these new biosimilar products. New research and clinical testing will have to occur and the FDA will implement regulations that will ensure this research is done safely and effectively. Biosimilars represent a tremendous growth opportunity for our burgeoning biotechnology industry in Kansas, and we need to work to see that new biotechnology products continue to reach patients and medical professionals.

As this new biosimilar market develops in the United States, we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into determining whether these products are interchangeable with the innovator’s products. Testing and research on these interchangeable biosimilar products should occur in this country to ensure that it is done properly and safely and to benefit our patients and our economy.

Ms. GRANGER. Mr. Speaker, I have criticized the majority of the provisions in H.R. 3962, the Affordable Health Care for America Act, and I will vote against it. However, I am amendment that I support, both include language relating to biosimilar products.

The provisions related to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted in a bipartisan vote for the Eshoo-Inslee-Barton amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time, provides a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this bill so that I could vote for it on its own. I believe that if this provision was considered on its own it would receive the support of Representatives with bipartisan support.

The biosimilar provisions in this bill are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively.

One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. With this week’s news that unemployment has reached 10.2 percent, it is critical that we preserve jobs in the United States. Testing and research on these generic biosimilars should take place in the United States to ensure that it is done properly and safely while benefiting our economy.

Innovative biotechnology companies have created jobs here in the United States and we must continue to support them.

Mr. PAYNE. Mr. Speaker, I an others have spoken at length on the ways that this bill will improve health care for all of our constituents. Another significant benefit of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in this country.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of Americans in this country who currently have no insurance will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. Influous of new patients will need doctors, nurses and technicians for their care, while reducing overall healthcare costs because they will not need much more expensive hospitalizations. Support channeling resources that for too long have been used to provide care once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will help us save millions of dollars while improving the quality of care. It will create high-quality health care at an affordable price.

Third, this bill will create high-quality research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to our health care system that is key to the full success of our healthcare system. Biotechnology is on the cutting edge of efforts to reducing costly invasive procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchangeable with an innovator’s product. This research will create high quality and high paying jobs and it is imperative that we keep this research and these jobs in this country.

We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.
I do not look at this bill as one of cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country while at the same time improving the lives of ALL Americans. This bill will improve health care, create jobs and grow our economy.

Mr. TERRY. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country.

As this new market launches in the United States, we need to ensure that we foster innovation and ensure the safety of any new product brought to the market.

Ms. CLARKE. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this legislation because it eliminates gender rating that allows young women to be charged 45% more than men for identical coverage.

Mr. POE of Texas. Mr. Speaker, H.R. 3962 forces businesses and individuals to purchase health insurance. It raises at least two constitutional issues. Congress should never pass unconstitutional legislation and consider it separate because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country.

As this new market launches in the United States, we need to ensure that we foster innovation and ensure the safety of any new product brought to the market.

Ms. CLARKE. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this legislation because it eliminates gender rating that allows young women to be charged 45% more than men for identical coverage.

Mr. POE of Texas. Mr. Speaker, H.R. 3962 forces businesses and individuals to purchase health insurance. It raises at least two constitutional issues. Congress should never pass an unconstitutional bill, and I will vote against H.R. 3962.

The Constitution doesn’t give the Federal Government direct authority to compel the purchase of health insurance. The Supreme Court would once again have to come in and by judicial fiat give the government the absolute power to do what it obviously cannot do now: stretch the meaning of the Commerce Clause.

Can the Federal Government force people to buy health insurance whether they can afford it? Federal Government enforcement then impose a criminal fine on them under the guise of calling it a tax if they fail to buy the insurance?

What happens if the citizen doesn’t pay the fine? Do they go to jail without the benefit of trial by jury? Do they lose their right to confront witnesses and have a lawyer?

Congress forcing mandatory health insurance on Americans and then imposing criminal sanctions without due process is a violation of the Constitution. This action would shock the Framers of our Constitution.

These serious constitutional issues cannot be ignored and I strongly oppose H.R. 3962 and any other bill that violates our Constitution.

Mr. Speaker, I am strongly against H.R. 3962, and I will vote against it should it come to a vote on the House floor. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country.

Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2% it is critical that we preserve jobs in the United States. While the innovators, have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can do so should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should occur in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. KIRK. Mr. Speaker, our goal in health care reform should be to lower the cost of health care, making it more affordable for Americans to purchase coverage. Many young adults from Illinois and elsewhere will be hit very hard under this legislation if they do not have coverage provided by their employers. We should not force young Americans to purchase coverage that costs them more because of reform. This is a new expensive tax targeted to young workers—and I oppose it.

According to the Department of Health and Human Services, 29 percent of individuals between the ages of 18 and 24 are uninsured and 27 percent of individuals between the ages of 25 and 34 are uninsured. Prices in the individual insurance market are already so high that I do not think this misnamed “Affordable Health Care Act” that we are debating now will make this coverage even more expensive.

The reason is that this bill requires that insurers may not charge 64-year-olds more than twice what they charge healthy 19-year-olds. This mandate will raise premiums on young adults tremendously. Young, healthy people who lack coverage, mostly because they find it too expensive at a current cost of $1,700 to $2,000 for it, will be forced to buy policies that cost $3,000, even after federal subsidies. The House bill’s “age rating” of 2 to 1 is far below the 5 to 1 ratio currently prevalent in the insurance market. Why does this ratio exist? Simply because the medical bills of healthy young people are a fraction of what older Americans spend. Comparisons of the House bill with an estimate of what is available on the individual market now using data provided by the Kaiser Family Foundation demonstrate that a 25-year-old single individual making $30,000 will pay a premium of $3,169 under the House bill after subsidies, while health standards with a 4 to 1 age rating cost $2,256. It is almost a $1,000+ leap. This is a big deal for those earning only $30,000.

The Kaiser Family Foundation provides a way to estimate how insurance premiums will rise for young workers and their families:

<table>
<thead>
<tr>
<th>Salary</th>
<th>House bill</th>
<th>Current market</th>
<th>Higher premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>$30,000</td>
<td>$2,724</td>
<td>$2,258</td>
</tr>
<tr>
<td>28</td>
<td>$35,000</td>
<td>$3,169</td>
<td>$2,258</td>
</tr>
<tr>
<td>30</td>
<td>$40,000</td>
<td>$3,169</td>
<td>$2,415</td>
</tr>
<tr>
<td>35</td>
<td>$42,000</td>
<td>$3,169</td>
<td>$3,076</td>
</tr>
</tbody>
</table>

I proposed an amendment to this bill that would ensure that anyone purchasing insurance coverage after January 1, 2013 is exempt from the individual mandate which is an expensive insurance plan than those available under today’s bill Act was available six months prior to its enactment. Unfortunately, this amendment was not made in order by the Rules Committee.

In health care reform, we should do no harm. We must enact reforms that will actually lower the costs of insurance premiums so Americans can afford to purchase coverage. Enacting a bill that makes it more expensive for young workers to buy insurance coverage and then forcing them to buy such coverage is worse.

In closing, I want to commend Shauna McCarthy of my staff for the many months she has committed to health reform, contributing to this amendment as well as the Medical Rights and Reform Act, which seeks to prevent government intervention in the important relationship between patients and their doctors.

Mrs. MALONEY. Mr. Speaker, Sunday, November 7, 2009, CONGRESSIONAL RECORD — HOUSE H12891

42,000 people gathered in my hometown of New York City to run the NYC marathon while 2 million more people watched, cheered, and marveled at those who accepted the challenge of running 26.2 miles. It is likely that each participant had a different reason for running, but the ultimate goal was the same: to finish.
succeed, and to accomplish a goal. As Greek legend explains, the concept of the marathon comes from the long distance a messenger ran to deliver the important news that the battle had been won. Mr. Speaker, as we stand here today to debate a historical bill that will substantially improve the delivery of health care in America, now is the time to take care of all Americans, now is the time to make sure that families are not forced to see loved ones die because they did not get the care they need and deserve.

I’d like to thank and commend the leadership of Speaker PELOSI, Majority Leader HOYER, Chairmen WAXMAN, MILLER and RANGEL and of course, Chairman EMERITUS DINGELL who has been working on health care reform since he first came to Congress. H.R. 3962, the Affordable Health Care for America Act, is a significant and important step toward securing accessible, affordable and quality health care for all Americans. Our current health care system is broken. Costs continue to increase at unsustainable rates and too many families and businesses are feeling the debilitating burdens brought on by these expenses. Too many Americans have inadequate coverage or lack coverage entirely and are suffering or dying as a result.

H.R. 3962 is critical to the health of our families, to the health of our economy and to the health of our nation.

H.R. 3962 strengthens Medicare, securing the financial stability and solvency of Medicare for years to come, and provides seniors with better benefits and guaranteed access to their doctors;

H.R. 3962 reduces the deficit by over $100 billion in the first 10 years, and likely by even more in the following decade, according to the Congressional Budget Office;

H.R. 3962 provides affordable coverage to those who cannot get health insurance because of pre-existing conditions, including domestic violence and pregnancy, and protects consumers from higher rates due to gender or other factors;

And, very importantly, I am proud that H.R. 3962 includes a public health insurance option that will increase competition and reform our current system. I am grateful to Speaker PELOSI, Majority Leader HOYER, and my colleagues in the House for their leadership and support of this important provision and am confident that it will expand access to care to the many people in need. When 14,000 Americans are losing their health care coverage each day, it is clear that a public option is needed. It will bring down costs, increase access, and improve care for all Americans. The richest country in the world should not have people who go without the basic necessity of health care. The public option will hold health insurance companies accountable for the practices that price people out of the health care they need and deserve.

Health care is the most important public policy issue of our generation that will affect generations to come. I am grateful for the opportunity to be a part of this momentous reform and would like to take the time to highlight some areas of the bill that specifically impact my Congressional district.

H.R. 3962 will improve employer-based coverage for 440,000 residents in my district and will provide credits to help pay for coverage for up to 120,000 households. It will also improve Medicare for 88,000 beneficiaries, including closing the prescription drug donut hole for 8,100 seniors. H.R. 3962 will allow 33,300 small businesses to obtain affordable health care coverage and provide tax credits for up to 31,300 small businesses and will cover 26,000 uninsured residents. In short, H.R. 3962 will make health care affordable for the middle class, provide security for seniors, and will guarantee access to health insurance coverage for the uninsured while reducing the federal deficit over the next ten years and beyond.

In addition to representing the residents of the 14th Congressional District of New York, I am proud to represent 14 hospitals. Many of these are the American health care system, training our nations’ doctors, and facilitating cutting edge research that identifies cures and gives hope to millions of Americans and their families. I am pleased that H.R. 3962 recognizes the importance of teaching hospitals and preserves Graduate Medical Education. New York’s teaching hospitals, while training our future physicians, are treating the sickest of the sick and poorest of the poor. These payments, including Direct Medical Education and Indirect Medical Education are critical to the survival of these hospitals and to the greater good of medicine.

H.R. 3962 takes into account diverse patient populations, the cost of goods and services, and the higher costs incurred by teaching hospitals. Teaching hospitals tend to treat the most complex cases and are the first to adopt innovative technologies and techniques that advance patient outcomes, so their costs are often higher than average. A policy that reduces spending arbitrarily runs the risk of stifling innovation which is why I am pleased that the bill is sensible on how it addresses geographic variation. This is the pit-falls of a blanket overhaul. It requires the Secretary of HHS to contract with the Institute of Medicine to conduct two studies. The first is a study of wage levels which will look at the hospital wage index and the physician geographic practice cost index and will recommend changes to the methodologies, if necessary. The second study looks at the geographic variation associated with volume and intensity of services in Medicare, Medicaid, and private sector spending per capita. The study will determine what causes geographic variation and separate out higher-than-average spending due to unavoidable or desirable factors (e.g., patient demographic and clinical risk factors and wage levels) from higher-than-average spending due to avoidable or undesirable factors (e.g., excessive medical errors, and practice patterns different from best practices). The bill wisely includes specific prohibitions against recommendations to reduce graduate medical education, disproportionate share, and health information technology payments.

While I am pleased with the bulk of the bill, I am concerned that H.R. 3962 does not extend the 340B discounts to drugs purchased for inpatient use, a provision that was included in an earlier version of the bill. Currently, the 340B Drug Pricing Program requires pharmacy manufacturers that participate in Medicaid to sell outpatient drugs at discounted prices to disproportionate share hospitals (DSH) that serve a high threshold of low-income, uninsured and underinsured patients. DSH hospitals are participating in the 340B Drug Pricing Program by approximately thirty percent more for their inpatient drugs than their outpatient drugs, although the drugs are frequently the same. The inpatient and outpatient settings serve the same low-income population that the 340B Drug Pricing Program is designed to assist. These discounts lower costs for patients and taxpayers. At a minimum, extending the 340B Drug Pricing Program to inpatient drugs would reduce inpatient drug costs by fifteen percent.

These new resources could be better used to provide direct patient care. I am hopeful that during Conference, the House will cede to the Senate language and extend the 340B drug pricing to inpatient drugs. After all, now is not the time to deprive safety net hospitals from millions of dollars in savings needed to treat the vulnerable and uninsured communities.

Mr. Speaker, the task is huge and the rewards even bigger. Today we will vote to cover 96 percent of Americans without adding a dime to the deficit. We will be doing what’s right for our families, what’s right for our economy, and what’s right for our future. I urge my colleagues to look at the larger picture and remember that today we will make a lasting difference in people’s lives.

Mr. TERRY. Mr. Speaker, I rise today to make the House aware of a seemingly silent crisis facing millions of Americans and to offer a potential solution. I am talking about the problem of personal medical debt, and the critical need for medical debt counseling. As a result, thousands of Americans in my state of Nebraska and throughout our nation are facing extremely difficult choices that severely impact their quality of life, and sometimes life itself.

Mr. Speaker, I am sure my colleagues are aware that medical debt is the number one cause of personal bankruptcy in this country. Let me say that again: 60 percent of all personal bankruptcies are caused by pressing medical debt. I know that my colleagues would agree that this is an astonishing, and indeed, an embarrassing statistic for our country.

In most cases, those who suffer from serious medical debt are people with chronic diseases who have just enough insurance to be considered insured. While they may technically be insured, the fact of the matter is that in reality they are severely underinsured. Simply put, they are faced with some extremely difficult choices between whether to pay their medical bills or pay for their basic needs. For example, someone with a chronic disease who is saddled with extremely high medical debt may have to choose between paying their mortgage or putting food on the table and paying the bill for life-saving treatments for their disease.

It is not hard to understand that when faced with these kinds of options more than half the time people chose to declare bankruptcy. That means that hospitals take a loss, individuals who have declared bankruptcy ruin their credit, and the American people in the end typically pay for it all.

Mr. Speaker and my colleagues, we can help fix this crisis with medical debt counseling.
The idea behind medical debt counseling is simple: Create a network of non-profit organizations that provide counseling services specifically for medical debt. The nonprofit counselors will provide the participants with a number of options long before the idea of bankruptcy is even considered. This is a safety net for even those who can avoid bankruptcy, and a health care provider such as a hospital or doctor, can receive payment for their services.

Nonprofit organizations with expertise in helping people with chronic diseases manage their burden, such as the Chronic Disease Fund which assists people in my state, should be put on the front lines of providing effective medical debt counseling. They are the experts which are best equipped to provide effective counseling so that individuals will not be forced into declaring bankruptcy because of their medical debt.

To my knowledge, there is nothing in the pending health care reform legislation that would help encourage medical debt counseling. This brings me to an important point. Because we have moved so fast on health care reform legislation, good ideas like medical debt counseling are not part of this bill. We need options like this for health care reform because it will work to save the American taxpayer money. Medical debt 2 counseling will reduce the burden on the health care system, not increase it. And medical debt counseling is innovative. It is innovation like this that made America’s health care the best in the world.

Mr. Speaker, my constituents, like yours, provide for their families but they live on a tight budget. When faced with the reality of making a huge medical bill payment or putting food on the table, what do you think they are going to do? We can help them avoid this terrible scenario. Again, 60 percent of bankruptcies in this country are because of crushing medical debt. We can help lower the number of personal bankruptcies across this great nation, but to do so we need to encourage a system of medical debt counseling.

Ms. KILPATRICK of Michigan. Mr. Speaker, I rise in support of H.R. 3962, Affordable Health Care for America Act, offered by Rep. JOHN DINGELL of Michigan and ask all of my constituents to vote YES on the bill because America cannot wait any longer for health care insurance reform. More than 300 groups, representing millions of Americans, have expressed their support for the bill, including the American Association of Retired Persons, the American Cancer Society, the National Union of Short Order Workers, the AFL-CIO, the SEIU, Families USA and the National Committee to Preserve Social Security and Medicare. The groups expressing their support include a broad range, including groups representing doctors, seniors, small business, youth, women, persons with disabilities, consumers and patients.

Health care insurance reform is not a Republican or Democratic issue, it is an American issue. Under a Democratic President, we witnessed the beginnings of health care reform with Medicaid and Medicare in the 1960s. Under another Democratic President, we will witness the second coming of true health care reform.

Today’s vote on H.R. 3962 marks a change in our country where every American will know that health care is a top priority for this country. When I was a newly elected Member to the U.S. House of Representatives, Congress was in the throes of reforming health maintenance organizations or HMOs. While this was well intended, at the time, I asked, “what about those millions of people who go to work each and every day, who care for our senior citizens in nursing homes, who clean our bathrooms, cook our food, clean our streets, and send their children to college, but whose employment has been lost? What has happened is that those individuals did not have health care coverage, period. Now is the time to help those janitors, street sweepers, short-order cooks, child care workers, home health care providers, and small businesses so that those workers, too, will be able to have health care.

The 111th Congress has taken bold steps to provide more access to health care for Americans. While we have expanded health coverage to more than five million uninsured children through the passage of the State Comprehensive Health Improvement Plan or SCHIP, we must complete what we started. Access to health care is vital to the health of not only individual Americans but to the American economy.

Even before our recent economic crisis, health care was getting more expensive, what few benefits were offered were eroding, and even more people were losing coverage. In 2007, according to various sources, 45 million Americans were uninsured; this number is an increase of uninsured Americans. And this is the uninsured; we are not even discussing the millions more senior citizens, working poor and families who are underinsured. I am talking about seniors who have to choose between taking their child to the doctor or food for the week. The economic crisis has only made this situation worse.

The bankruptcy of the automobile industry, the closing of auto dealerships, and the crisis faced by auto workers have caused hundreds of thousands more in our Nation and in particular the state of Michigan to lose their employee health benefits.

Our version of health care reform, the Affordable Healthcare for All Americans Act, has four key highlights for Americans and American businesses: lower costs; greater choice; higher quality and peace of mind. As Health and Human Services Secretary Sebelius said earlier, if we do nothing to reform health care, we will continue to live sicker, die faster and pay twice what we do today.

Health care reform legislation should require coverage of the full range of women’s reproductive health services. H.R. 3962 protects these rights and ensures that all women have access to a health care plan that meets their needs while respecting current law. The Stupak amendment would limit access to reproductive care in the private and public options, and does not allow citizens to pay for the procedures out of their own pockets. I voted against the Stupak amendment.

HEALTH CARE REFORM WILL PROVIDE LOWER HEALTH CARE COSTS

Under the America’s Affordable Health Care Act, there will be no more co-pays or deductibles for preventive care. No more rate increases for exclusions for pre-existing conditions, gender or occupation. There will be an annual cap on the out of pocket expenses for individuals and businesses. Finally, for the first time, there will be guaranteed and affordable oral, hearing, and vision care for children.

By having a public health care plan, the bill will ensure competition for Americans to have the best health care at the most affordable cost. Also, since everyone will have health care, no one industry or business will be at an advantage over another one.

HEALTH CARE REFORM WILL PROVIDE GREATER CHOICE FOR ALL AMERICANS AND BUSINESSES

Americans will be able to keep their doctor, and their current plan, if you like what you have. With a high quality public health insurance option competing with private insurers, there will be more choice of providers and more benefits. The important aspect is this—every American will have a choice of providers, versus today’s choice, for the uninsured, of the emergency room or no care at all. No one will be forced into a public option. This will just be one of many choices.

HEALTH CARE REFORM WILL PROVIDE HIGHER QUALITY HEALTH CARE FOR ALL AMERICANS AND BUSINESSES

You and your doctor—not insurance companies—will make health care decisions. As more primary care, family doctors, and nurses enter the workforce, even more access is guaranteed for all Americans. Also, the bill mandates coverage for mental health care, a key issue that will affect, in particular, the families of our service members who are returning from the wars in Iraq and Afghanistan.

HEALTH CARE REFORM WILL PROVIDE PEACE OF MIND

The bill provides a cap on catastrophic coverage—coverage for traumatic injuries such as spinal cord injuries and long-term health care. There will be no more denial of coverage for preexisting conditions, and no reason to make a life or job decision based on whether or not you or your family will have health care coverage.

We need health insurance reform now. Access to quality, affordable health care is critical to the well-being of Americans and all Americans, today and tomorrow. Central to all of this is addressing the needs of uninsured Americans, strengthening our Medicare system, providing health insurance to low-income children and families, funding research into diseases like diabetes and cancer, and giving patients the ability to make decisions with their doctors, not health insurance companies. An estimated 1,400 families lose health insurance every day that we do not pass health insurance reform.

One aspect of this legislation of which I am most proud is its fiscal responsibility. According to a letter dated November 5, 2009 from the non-partisan, objective Congressional Budget Office, this bill adds not one dime to...
the deficit. Furthermore, this bill reduces the deficit by an estimated $109 billion. This is not only fiscally responsible, it allows us to provide health care to the least of our sisters and brothers.

When this bill is signed into law, ten provisions of the bill will take effect immediately.

It will begin to close the Medicare Part D “Donut” Hole. The bill reduces the donut hole by $500 per Medicare recipient and also institutes a 50-percent discount on brand-name drugs.

It gets health insurance to the uninsured. By creating a temporary insurance program, health care will be available for people who have been denied a policy due to preexisting conditions or who have not had health care for several months. It bans lifetime limits on health care coverage. The bill prohibits health insurance companies from placing lifetime caps on coverage—traditional coverage or catastrophic care coverage.

It provides health insurance for young people. It requires health insurance plans to allow young people, age 26 to 30, to remain on their parents’ insurance policy at their parent’s choice.

It eliminates cost-sharing for preventive services in Medicare. It eliminates copayments for preventive services and exempts preventive services from deductibles under the Medicare program.

It ends health care rescissions. It prohibits insurers from nullifying or “rescinding” a patient’s policy when they file a claim for benefits, except in cases of fraud.

It bans lifetime limits and deductibles. It eliminates copayments for preventive services and also exempts preventive services from deductibles under the Medicare program.

It increases funding for community health centers. It increases funding for Community Health Centers to allow twice the number of patients seen by Community Health Centers for the next 5 years.

It increases the number of primary care doctors. It increases the investment by the Federal Government in training programs to increase the number of primary care doctors, nurses, and public health professionals.

Creates long-term health care for disabled adults. The bill creates a long-term care insurance program to be financed by voluntary pay-roll deductions to provide benefits to adults who become functionally disabled.

As with Medicare and Medicaid, the Federal Government has the Constitutional power to reform our health care system. The 10th amendment to the U.S. Constitution states that the powers not delegated to the federal government are reserved to the states, are reserved to the states. . . . or to the people. Article One, Section Three, also known as the Commerce Clause, says the same thing. The Constitution gives Congress broad power to regulate activities that have an effect on interstate commerce. Congress has used this authority to regulate many aspects, from labor relations to education to health care to agricultural production. Since virtually every aspect of the health care system has an effect on interstate commerce, the power of Congress to regulate health care is essential.

The Affordable Health Care for America Act is good for small businesses. Under this legislation, many small businesses will be eligible for a new tax credit to help them provide coverage for their workers and their families—and they or their workers will get access to a new comparison shopping marketplace with low rates and good benefits like large groups get. Without health insurance reform, small businesses would pay nearly $2.4 trillion over the next 10 years for their workers. According to the nonpartisan Joint Committee on Taxation—only 1.2 percent of the wealthiest Americans will be subject to the surcharge and it would only apply to dollars earned over $1 million for a couple and $500,000 for a single taxpayer. 86 percent of all businesses are exempt from the requirement to provide health insurance coverage to their workers.

Nothing in the House bill will cut basic Medicare benefits. The Affordable Health Care for America Act strengthens and improves Medicare benefits for older Americans and helps eliminate waste, fraud and inefficiency from Medicare—including gross overpayments to insurance companies providing Medicare Advantage plans which do nothing to improve care for Medicare beneficiaries.

The Affordable Health Care for America Act is comprehensive health insurance reform that covers 96 percent of Americans, ensures affordability for the middle class, provides security for our seniors, ends discrimination by insurers, eliminates lifetime limits and caps, what Americans pay out-of-pocket and protects our children’s future by not adding to our deficit.

Finally, health care reform will allow the United States to catch up to the rest of the industrialized world. We are the only nation that puts the health of our economy in jeopardy.

Health care reform will allow the United States to be the creation of new high paying jobs, high skilled jobs that are needed by American businesses and American families. Another significant benefit of this legislation, which has not received as much attention, will be the creation of new high paying jobs, high quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring that the millions of Americans, who currently have no insurance, will have access to primary care providers so that they can receive the preventive care they have been denied for too long. This influx of new patients will create a need for doctors, nurses and technicians, while reducing overall healthcare costs because of the new focus on preventative medicine.

I support channeling healthcare costs because of the new focus on preventative medicine. I support channeling our healthcare dollars into preventative medicine and also exempted preventive services from deductibles under the Medicare program.

I applaud my colleagues in the House of Representatives for supporting this legislation in ensuring that health care reform is accessible, affordable, and affordable for all Americans and American businesses. Two generations is long enough for the American people to wait for comprehensive health care reform. Health care is the key moral and economic imperative for our Nation and this Congress. We must reform health care now.

Ms. CLARKE. Mr. Speaker, today, I rise in support of the Affordable Healthcare for America Act. In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance, 13.5 percent of which are New Yorkers. Last year alone, New York City’s hospitals spent 1.2 billion dollars in charity costs. Tragically, people who are either uninsured or underinsured often have to go without vital healthcare simply because they cannot afford it.

Every American has a human right to adequate physical and mental healthcare, and I believe that government has a responsibility to make sure that quality healthcare is affordable.

Unfortunately, my Republican colleagues don’t seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare system.

It is unfortunate that there are those who just don’t care. Those who are satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of pre-existing conditions or who have become functionally disabled and ignored the pain of the 47 million Americans who are uninsured. Instead of working to fix the problem, they capitalize on people’s fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens and other countries with the voices of fear to dominate the health care reform debate. This bill provides health care coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Health Care for America Act.

In my district, the 11th Congressional District of Brooklyn, the Affordable Health Care for America Act will:

First, improve employer-based coverage for 367,000 residents. As a result of the insurance reforms in the bill, the most common ways or deductibles for preventive care; no more rate increases or coverage denials for pre-existing conditions, gender, or occupation; and guarantees of benefit for children.

Second, it will provide credits to help pay for coverage for up to 160,000 households, if they need to purchase their own coverage.

Third, under the bill’s insurance reforms, 11,900 individuals in the district who have pre-existing medical conditions will now be able to purchase affordable coverage.

Finally, this bill will allow 11,300 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 11,400 small businesses.
manage both the quality of care and the cost of it. New health care exchanges and new demands on the health system to provide high quality and cost-effective health care will create new opportunities and markets for our brightest technological minds. They will be incented to transform high-quality healthcare products at an affordable price.

Third, this bill will create new research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures, thereby allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing. This research will create high quality, high paying jobs. It is imperative that we keep this research, and these jobs in this country. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

I do not look at this bill as a drain on our economy, like so many of its opponents on the other side of the aisle would have you believe. I see this bill as an opportunity to create the kind of jobs we so desperately need in this country, while at the same time improving the lives of all Americans. This bill will improve health care, create jobs at home, and make our economy stronger.

Mr. FATTAH. Mr. Speaker, in my fourteen years representing the people of Philadelphia and Montgomery County, Pennsylvania, I have had few opportunities as significant as this one to stand up for my constituents, their families, the future of our city and the destiny of our nation. This healthcare bill is the result of months of legislative negotiation and collaboration and answers the calls made for decades by mothers who could not alleviate the suffering of their children, conscience-minded small business owners who could not provide the healthcare they knew their employees deserved and doctors and nurses who fought creatively to provide treatments they knew their patients needed and could never afford. I am proud that today we will take the most significant step in a century towards joining the rest of the industrialized world in assuring every American has access to the healthcare they need.

It is the nature of democracy that this bill contains some provisions which I do not support. I believe women deserve access to the full range of legally assured health services on equal footing with men. I believe it is our responsibility to vigorously address the pernicious health disparities which disadvantage Americans of color and linguistic minorities. I believe overzealous efforts to deny some people health care on the basis of their immigration status will inadvertently limit care for native-born and legal residents as well. I believe a stow public option is the only way to ensure competition, choice and affordability in the American private insurance market. At the end of the day, we, and the Representatives of the people of this country, have the opportunity to speak for them. Rarely do we have the opportunity to so directly improve their standard of living. It is with the people of the Second District in mind, and the generations to come, that I enthusiastically vote yes for the Affordable Care Act for America Act.

Ms. WOOLSEY. Mr. Speaker, at least 46 million Americans are uninsured right now. More than 85% of the uninsured are in work eligible families and cannot afford insurance. Now, without reform, the cost of health care for the average family of four is projected to increase by almost $2,000 a year. The need for health reform is urgent and that’s why I’m in strong support of this historic bill.

Many Members of Congress, myself included, continue to believe that the best way to provide high quality, affordable healthcare to everyone is to create a single payer health insurance system. However, while we would prefer single payer, we united behind a health reform bill with a robust public option.

We believed, and still believe, that the robust public option, a public option based on Medicare plus 5% rates is the best way to increase competition, bring down the costs of premiums, and provide everyone with a real choice between a private and public health insurance plan.

In August, many thought the public option was dead. But the Progressive Caucus, Tri Caucus, and many in our leadership, made sure that the robust public option was very much a part of the debate in September and October.

Because of the work of so many Members, we have a public option in the bill we are considering today. While it’s not the plan I would have preferred, this public option will increase competition with private plans and provide a real choice in health insurance.

In addition, there is language in the manager’s amendment that will ensure that any increase in health insurance premiums must be justified, which will help make premiums more affordable for our Nation’s working families.

As we move into conference with the Senate, I look forward to continuing to work with my colleagues to ensure that we have the best possible bill. Therefore, Mr. Speaker, to increase competition and provide choice, any bill reported out of conference must retain a strong public option. Workers and their families will benefit when the health exchange begins, and, is not based on any triggers. I urge my colleagues to support this bill.

Mr. HARE. Mr. Speaker, I wish to strongly voice my support for the Affordable Health Care for America Act on behalf of all hard working men and women across this great country and certainly in the State of Illinois.

For decades, our government has debated the issue of extending healthcare to all, yet too many Americans still lack it and the security and peace of mind that comes with it. For those fortunate enough to be insured, rising costs are making it harder and harder to stay afloat. We, as members of this body, have the opportunity today to take a historic step toward passing the Affordable Health Care for America Act, so that quality health care can be more affordable and accessible to all Americans and their families. This bill will drastically reduce the number of uninsured, increase competition and lower costs through a public option, reform the insurance industry so Americans don’t lose their coverage unfairly, enhance access to, and put more money in our seniors’ pockets by closing the Medicare Part D doughnut hole, all while reducing the deficit by $104 billion over 10 years.

With unemployment at its highest level since 1983, another significant benefit of this legislation that should be highlighted is the creation of new high-paying jobs in this country. Let me repeat, that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in the delivery, testing, and research in the United States.

This bill creates a framework for allowing biosimilar competition in this country, which has the potential to lead to a new class of generic biologic medicines that will help lower costs and bring competition to a class that will be key to the future of our healthcare system. The development of generic biologics or biosimilars has the potential to create much needed jobs here at home in clinical research and testing. I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that this new work is conducted here at home, in places like my home state of Illinois.

This bill will additionally create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of Americans who currently have no coverage will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and technicians for their care, which will create overall jobs because they will receive care based around prevention as opposed to hospitalization. I support channeling resources, that for too long have been used to treat people once they become sick, into jobs and services that will prevent people from getting sick in the first place.

The Affordable Health Care for America Act will continue the efforts this Congress first undertook in the Recovery Act that deployed new health information technologies throughout our healthcare system. These technologies help to better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our health care providers. They will be incentivized to create and develop products that will be a win/win for Americans: high quality health care at an affordable price.

I was proud to work with my colleagues on the Education and Labor Committee to help shape this bill. I was pleased to have had the opportunity to add two critical pieces to this bill that are of great importance to my constituents: allowing for Small Employer Benefit Arrangements (SEBA), which facilitate the participation of small businesses and the self-employed in the Health Insurance; and protecting the ability of our nation’s veterans to be able to enter into the Health Insurance Exchange to attain additional insurance for their dependents while retaining their VA health coverage. These provisions were common-sense improvements that make this great bill even better.

I have cited many, but not all, of the reasons why I think this historic bill is worthy of my vote. I now ask that my colleagues join me in protecting American families from coast to coast in supporting this historic legislation. Mr. Speaker, thank you for your strong leadership on this issue and I look forward to proudly voting in favor of this bill in honor of the 39,000 uninsured residents of my District who would
finally have the ability to receive the quality health care they deserve.

Mr. PASCRELL. Mr. Speaker, I and others have spoken at length on the ways that the Affordable Health Care for America Act will improve health care for all of our constituents. Another benefit of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle: this bill will create high-paying, high-quality jobs in health care delivery, technology, and research in the United States.

First, H.R. 3962 will create enormous demand for health care workers, especially in the area of primary care. Expanding meaningful health insurance coverage to the millions of Americans in this country who are currently uninsured or underinsured will allow them to see the primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need the doctors, nurses, and technicians necessary to deliver the care they need—while health care costs continue to rise, we must prevent more expensive emergency care and hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, the Affordable Health Care for America Act will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective care will create new opportunities and markets for our brightest minds in technology. They will be incentivized to create and develop products that will be a win-win for Americans—high quality health care at an affordable price.

Third, H.R. 3962 will create high quality research opportunities for America. The legislation under consideration establishes a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to an area that is a key to the future of our health care system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures and allow our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of new biosimilars’ interchangeability with innovator products. This research will lower costs and bring competition to an area that is imperative that we keep this research and these jobs in this country. The Inspector General of Health and Humans Services is currently investigating the amount of data received from overseas clinical trials. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that the clinical studies to support the safety and interchangeability for this new class of follow-on biologics is conducted in the United States.

Mr. Speaker, I do not view this legislation as a cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. Instead, the Affordable Health Care for America Act is an exciting opportunity to create the kinds of jobs we so desperately need in this country while improving the lives of ALL Americans. H.R. 3962 will improve health care, create jobs, and grow our economy.

Mr. PASCRELL. Mr. Speaker, I am pleased to support the Affordable Health Care for America Act. I could not be prouder that H.R. 3962 expands coverage to 96 percent of Americans in a fiscally responsible manner. I strongly believe that all interested parties should fund this necessary effort, but I would like to recognize the contributions asked of the biopharmaceutical industry.

New Jersey has often been called the Medicine Chest for the World and for good reason. Last year, the biopharmaceutical and medical technology industries employed nearly 60,000 individuals in the state of New Jersey—with another 88,000 “spin-off” jobs through the purchase of goods and services, capital construction projects, and other industry activity. H.R. 3962 extends Medicaid payments to Medicare dual-eligible and low-income subsidy beneficiaries while instituting a new 50 percent discount for Part D beneficiaries who find themselves in the prescription drug benefit coverage gap—the so-called “donut hole.” Pharmaceutical sales represent about 10 percent of national medical expenditures, but the savings generated from these provisions represent a disproportionately larger share of the legislation’s savings and revenues.

There is little doubt that these industries are sure to see a surge in demand both as millions of previously uninsured Americans and millions more who were underinsured are given access to meaningful health insurance that covers prescription medications and as seniors with expanded Part D coverage better adhere to the prescription regimens prescribed by their doctors. However, I have lingering concerns that a single industry may be paying more than their fair share and that this may have unfortunate consequences in New Jersey. The biopharmaceutical manufacturers in New Jersey were estimated to contribute approximately as 12,300 jobs could be lost in New Jersey.

I believe that H.R. 3962 is an effort that will indeed create new jobs in the health care sector both as the demand for health care providers increases and as the result of a new pathway for the development of follow-on biologics, and I applaud the legislation for taking steps to close the Medicare Part D donut hole. However, we must recognize there will be consequences for New Jersey’s biopharmaceutical industry, and I express my hope that these consequences will be minimized as the House and Senate come together to formulate a compromise health reform package.

Mr. PASCRELL. Mr. Speaker, in my capacity as co-chair of the Congressional Brain Injury Task Force, I would like to share my understanding of the impact of the provisions of H.R. 3962—more Affordable Health Care for America Act—regarding the coverage of the treatment continuum for persons with brain injury.

News reports of returning veterans and recent high profile brain injury stories indicate that for many years: brain injury is a leading public health problem in U.S. military and civilian populations. I believe that any health care reform initiative must recognize that brain injury is not an event or an outcome but is the beginning of a lifelong disease process that impacts brain and body functions. These impacts of brain injury can result in difficulties in physical, communication, cognitive, emotional, and psychological performance, undermining health, function, and quality of life. The goal of care must be the restoration of functional independence and productive living. Brain injury is also disease causative and disease accelerative because it predisposes individuals to re-injury and the onset of other conditions.

The Brain Injury Association of America (BIAA) has developed a series of guiding principles for assessing any health care reform bill from a brain injury perspective. I believe, consistent with policy statements by the BIAA, that health care reform must address the unique health care needs of individuals with brain injury recognizing that brain injury is the start of a lifelong disease process. As such, individuals with brain injury require access to a full continuum of medically necessary treatment—including rehabilitation furnished by accredited programs in the most appropriate setting as determined in accordance with the choices and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to conclude that the Affordable Health Care for America Act reflects and is consistent with these principles.

Principle 1: An individual with a brain injury should have an individualized medical treatment plan that documents specific diagnosis-related goals for individuals with a reasonable expectation of recovery and additional improvements through the provision of sufficient treatment.

Under the bill, payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical and other appropriate clinical or professional practice. In addition under the bill, a qualified health benefits plan may not impose any restriction (other than cost-sharing) unrelated to clinical appropriateness on the coverage of the health items and services included in the essential benefits package. Consistent with medical, clinical, and professional practice, appropriateness should be determined based on the unique needs of the individual with brain injury and treatment should be of sufficient scope, duration, and intensity.

Principle 2: An individual with brain injury should have access to the full treatment continuum to manage the disease. This continuum includes (1) early, acute treatment to stabilize the condition and (2) acute and specialized treatment for acute brain injury treatment and rehabilitation to minimize and/or prevent medical complication, recover function and cope with remaining physical or mental disabilities, and achieve long-term outcomes that maintain an optimal level of health, function, and independence following brain injury. These post-acute care elements include inpatient, outpatient, day treatment, and home health programs. I believe that for individuals with disabilities such as brain injury, rehabilitation and habilitation is equivalent to the provision of antibiotics to a person with an infection—both are essential medical interventions.

I am pleased to report that under the bill, the essential benefit package includes, among other things, hospitalization, outpatient hospital
and outpatient clinic services, professional services of physicians and other health professionals, prescription drugs, mental health and substance use disorder services (including behavioral health treatments), rehabilitative and habilitative services, and durable medical equipment, prosthetics, orthotics, and relates supplies (collectively referred to as “habilitative services”) includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, or condition other health condition. Such services also include training of individuals with mental and physical disabilities to enhance functional development.

Principle 3: Individuals with brain injury should receive treatment in the most appropriate treatment setting by accredited programs—including acute care hospitals, inpatient rehabilitation facilities, residential rehabilitation facilities, day treatment programs, outpatient clinics and home health agencies. The treatment and treatment setting should be determined consistent with the care needs of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to report that under the bill, payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical or other appropriate clinical or professional practice. The bill also requires adequacy of provider networks in order to ensure enrollee access to covered benefits, treatment, and services under a qualified health benefits plan. Rehabilitative and habilitative services should be available from a full continuum of accredited programs and treatment settings at a level of intensity that is consistent with the needs of the patient.

Principle 4: The bill should prevent private insurance systems from delaying or denying treatment as a means of transferring the burden of brain injury care to taxpayers at federal, state and local levels; ensure that both public and private health insurance systems meet the health care needs of people with brain injury; and avoid using Medicaid and Medicare as the first option for the coverage of people with brain injury.

I am pleased to report that the bill includes numerous requirements reforming the health insurance marketplace that should prevent private insurance systems from delaying or denying treatment for individuals with brain injury. These reforms include (1) prohibiting pre-existing condition exclusions, (2) requiring guaranteed issue and renewal, (3) requiring non-discrimination in benefits or benefit structure, (4) requiring adequacy of provider networks, (5) limiting cost-sharing, and (6) prohibiting the imposition of annual or lifetime limits on coverage. I believe that these provisions will help prevent private insurance from delaying or denying treatment to persons with brain injury.

Finally, the bill includes provisions regarding modernized payment initiatives and delivery system reform under which the Secretary may use innovative payment mechanisms and policies to determine payment for items and services under the public health insurance option, including bundling of services. Separate provisions are included in the bill regarding post-acute care bundling under Medicare. BIAA, in a recent submission to the chairs of the Education & Labor, Ways & Means, and Energy & Commerce Committees, commented that post-acute payment systems must facilitate, not impede, improvements in functional status of individuals with brain injury and their ability to return to their homes and communities. BIAA opposed the delay and rigorous pilot testing. According to BIAA’s comments, the deliberative process should determine whether post-acute care bundling should exempt diagnoses such as brain injury, that are of low predictability and highly complex, and establish minimum requirements for any bundling proposal such as “any willing provider” in the bundled payment system; and test innovative payment methods that make payments directly to non-hospital-based treatment centers, including residential rehabilitation facilities specializing in the treatment of brain injury.

I believe that the deliberative process should address each of these issues. I also believe that the adoption of alternative innovative payment mechanisms and policies must be guided by the goal of improving health outcomes, reducing health disparities, providing efficient and affordable care, addressing geographic variation in the provision of health services, preventing or managing chronic illness, and promoting care that is integrated, patient-centered, quality, and efficient.

I remain wary of mechanisms that bundle post-acute care to acute care hospitals for patients with complex and highly unpredictable diagnosis and health outcomes, like brain injury and other catastrophic conditions. Such payment systems should not impede, rather than facilitate, improvements in functional status and should not result in premature return to homes and undue levels of preventable disability without adequate facilitation of progression through necessary step down levels of treatment.

Mr. Luetkemeyer. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so.

However, one bi-partisan area that strikes me is the potential for innovation in providing lower-cost, better options to consumers without destroying a healthy and functioning industry in this country that is included in both the underlying bill, which I strongly oppose, and the Republican substitute, which I intend to support, are the sections relating to the creation of a market for biosimilar products. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that don’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time, providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2%, it is critical that we preserve jobs in the United States. While the innovators have created jobs here, these generic companies have shipped them off to places where they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can is occurring in this country not somewhere else across the globe. Testing and research on these interchangeable biosimilars should be occurring in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. EDWARDS of Texas. Mr. Speaker, after listening to thousands of my constituents and carefully reviewing the legislation, I have made a decision to vote “no” on the House health care reform bill.

Given the huge federal deficits facing our nation, I believe there is too much new spending in this bill.

I am especially disappointed that the bill does not have a fiscal trigger in it to cut spending if actual costs of new programs turn out to be higher than projected.

I also have concerns about a government-run “public option” insurance company and question whether this bill goes far enough in actually reducing health care costs for working families and businesses.

Throughout this debate I have heard two extremes. Some on the far left would like to see the federal government run a socialized health care system. Some on the far right would get the government completely out of health care, which would mean the elimination of Medicare and Medicaid. I think both extremes are wrong.

I believe most people in our district recognize that health care reform is needed to hold down costs and to make health care more affordable and dependable, but they want any reform bill to be fiscally responsible. I agree. Mr. SHUSTER. Mr. Speaker, after weeks of closed-door meetings, Speaker NANCY PELOSI has brought her healthcare reform to the floor for a vote today on Saturday while the attention of the majority of Americans is diverted. The Pelosi plan clocks in at over 1,900 pages, which is 648 pages longer than Hillary-care and it costs over a trillion dollars, or about $2 million per word.
not accept a government takeover of healthcare that will kill even more jobs, hurt small businesses, increase the deficit now and drown future generations in stifling debt.

While the sheer size and scope of the Democrats’ takeover of healthcare prevents me from pointing out every egregious part of the proposal, I would like to point out four areas that should give all Americans pause.

**Taxes:** The Pelosi plan would impose $730 billion in new taxes on businesses that can’t afford to pay for their employees’ health coverage. According to President Obama’s own economic advisor, Christina Romer, these new taxes would put 5.5 million workers at serious risk of losing their jobs. Close to 32,500 small businesses in Pennsylvania would be at risk from this new healthcare surcharge.

**Deficit Spending:** The Pelosi plan contains $1.055 trillion in new federal spending over the next ten years. All of this spending will be used to take healthcare decisions out of the doctor’s office and centralize them in Washington, DC, requiring the creation of over 100 new federal panels, commissions and unelected civil servants who will be charged with making decisions on your care.

**Senior’s Coverage:** Earlier this year, President Obama pledged that “the government is not going to make you change plans under health reform.” Today, he and NANCY PELOSI are proposing cuts to Medicare Advantage. These cuts would force close to 38,000 enrollees in the 9th district out of Medicare Advantage and into regular Medicare.

**Personal Freedom:** The Pelosi plan will bring the nationalization of one-sixth of our economy and the elimination of choice for a majority of Americans to extend coverage to a few.

Republicans have an alternative focused on simple principles that will lower the cost of quality healthcare for all Americans. Our plan would let families and businesses buy health insurance across state lines and pool together and buy health insurance at lower prices. We would give states the tools to create their own innovative reforms that lower health care costs. Finally our plan would end excessive costs. We know that these new taxes will have a direct and adverse affect on small businesses across America. An overwhelming majority of small businesses—approximately 75 percent of them—pay their business taxes through the owner at the individual level. Essentially, one in every three small businesses would be subject to the new surtax and just in the State of Florida alone, the additional costs associated with the Medical Device Tax would be about $700 million dollars.

Mr. Speaker, we are told by the President and by the majority party in Congress that we need all this in order to make health care more affordable for the American people. How are we making health care more affordable if we are taking people into bankruptcy by taking historic steps toward a federal takeover of the entire health care system?

The Democract Majority seeks to pay for their health care reform bill in part through 8 percent payroll penalty taxes on employers who cannot afford to provide insurance coverage, and through a 5.4 percent surtax on individuals making $500,000 a year or more. These provisions are estimated to bring in more than $595 billion.

You don’t have to be an economist to know that these new taxes will have a direct and adverse effect on small businesses across America. An overwhelming majority of small businesses—approximately 75 percent of them—pay their business taxes through the owner at the individual level. Essentially, one in every three small businesses would be subject to the new surtax and just in the State of Florida as many as 57,000 small businesses would be affected. These provisions are effectively a tax on jobs that will stifle job creation and depress wages. In light of the latest unemployment numbers of 10.2 percent for the U.S. and 11 percent for Florida, this is hardly the time to raise costs on small businesses and employ-

If the taxes on America’s small businesses were not enough, this bill also imposes a 2.5 percent tax on medical devices. At a time when our country spends about 17 percent of its GDP on health care, and we are tasked with developing policies to bring down the overall cost of care, it is irrational that we should tax an industry that is such an integral part of health care. This tax, on everything from syringes to artificial hips, will undoubtedly be passed along to the consumer.

Mr. Speaker, America has the best health care system in the world. Why should we destroy the economic backbone of America to create a government-run health care plan that the majority of Americans oppose? It does not have to be this way.

We can take significant steps to address health care—steps guided by principles based on choice, openness, and a competitive free market.

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

The Republicans are establishing a universal access program to guarantee access to affordable health care for people with pre-existing conditions.

The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to “junk lawsuits.” The fear of lawsuits drives doctors to order expensive tests and procedures for pa-

We can promote prevention and wellness by giving employers greater flexibility to finan-

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

We can take significant steps to address health care—steps guided by principles based on choice, openness, and a competitive free market.

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

The Republicans are establishing a universal access program to guarantee access to affordable health care for people with pre-existing conditions.

The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to “junk lawsuits.” The fear of lawsuits drives doctors to order expensive tests and procedures for pa-

We can promote prevention and wellness by giving employers greater flexibility to finan-

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

The Republicans are establishing a universal access program to guarantee access to affordable health care for people with pre-existing conditions.

The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to “junk lawsuits.” The fear of lawsuits drives doctors to order expensive tests and procedures for pa-

We can promote prevention and wellness by giving employers greater flexibility to finan-

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

The Republicans are establishing a universal access program to guarantee access to affordable health care for people with pre-existing conditions.

The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to “junk lawsuits.” The fear of lawsuits drives doctors to order expensive tests and procedures for pa-

We can promote prevention and wellness by giving employers greater flexibility to finan-

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

The Republicans are establishing a universal access program to guarantee access to affordable health care for people with pre-existing conditions.

The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.
I urge my colleagues to vote “no” on this bill.

Ms. JENKINS. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslsee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time provide a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bipartisan support that American companies and the American people want to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA will write rules that will ensure that research is done safely and effectively. I have long supported the U.S. biotechnology industry as it has been a strong engine of job creation in this country. Unfortunately, many large companies that seek to test and develop their research in foreign countries. With this week’s devastating news that unemployment has reached 10.2 percent, it is critical that we preserve jobs in the United States.

As this new market launches in the United States, we must foster innovative products at home to create jobs, and conduct research that will prove whether products are interchangeable with innovator’s products. It is unlikely that these companies can create such interchangeable products; however research and development that will be conducted within our borders without being outsourced.

Mr. EHLERS. Mr. Speaker, on November 14, 2009, Northrop Grumman will lay the keel of the first ship of the new Gerald R. Ford class of nuclear-powered aircraft carriers, the USS Gerald R. Ford (CVN–78), in Newport News, Virginia. Susan Ford Bales, the daughter of President Ford, is the ship’s sponsor and will serve as the keel authenticator for the ceremony.

President Ford was a good friend of mine, and I am honored to hold his former seat in the U.S. House of Representatives. In 2006, I supported an amendment to the 2007 National Defense Authorization Act, offered by then Senator John Warner, which expressed the sense of Congress that the CVN–78 should be named after President Gerald R. Ford. On January 16, 2007, the U.S. Navy followed Congress’s instruction and announced that CVN–78 would be so named. Consequently, CVN–78 and other carriers built to the same design will all be referred to as “Ford class carriers.”

The Gerald R. Ford class carrier design is the successor to the Nimitz class design, and it incorporates several improvements, such as allowing more sorties per day and requiring fewer sailors for its operations and maintenance. Expected to enter into service in 2015, the U.S.S. Gerald Ford, and its Ford class successors, will ensure that the U.S. Navy, and policymakers, will continue to have the assets they need to adequately defend our nation and protect our allies and interests around the globe.

President Ford served his country honorably and faithfully for more than 60 years, first as a Navy officer during World War II, then as a Congressman, Vice President and finally as President and former President. I believe it is fitting that we name this new class of aircraft carriers after President Ford, and I look forward to monitoring the future success of the U.S.S. Ford.

Mr. HONDA. Mr. Speaker, in our lives as public servants, Members of Congress are rarely presented with opportunities to support the passage of truly historic legislation. Today is such a day, and this health care vote such an opportunity. Over the past ten months that I have participated in the creation of this health reform bill, I have been thinking about the words of Hubert Humphrey: “It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.”

Today I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. For 70 years Americans have been waiting for this moment. I would like to particularly thank Speaker Pelosi for her leadership and management of a complex policy debate. Majority Leader HOYER, Majority Whip CLYBURN, the Chairs of the Committees on Energy and Commerce, Education and Labor, and Ways and Means, along with my fellow progressive and colleagues in the Congressional Asian Pacific American Caucus, Congressional Black Caucus, and Congressional Hispanic Caucus (collectively known as the TriCaucus) for their public and private commitments to preserve the public option. Finally, I commend staff of all the committees for their hard work and commitment to this issue.

Against an organized, scorched earth campaign of misinformation and fear mongering, we are emerging with a strong bill, and an even stronger sense of unity and purpose in our fight to bring access, affordability, and quality health care to all American workers and American families. The Affordable Health Care for America Act is such a day, and this health care vote such a day.

I urge my colleagues to vote “no” on this bill.
health care reform. Native American communities worked for over a decade to come together and write policy that would help their communities begin to address the terrible and tragic health disparities they experience and the inclusion of ICHIA is a step in the right direction by the Federal Government to rectify some of the harms and abuses that they have caused in Native communities.

Despite the many extraordinary improvements to many aspects of our healthcare system, including an unprecedented expansion of access to Medicaid for many poor families, I am dismayed that we are not able to lift the 5 year bar on legal immigrant participation in Medicaid. Legal immigrants are tax paying citizens in waiting who work hard and contribute. It is only fair that we afford them equal access to the benefits of Medicaid. I will continue to advocate on this issue in the future and I know that I am joined in my concern by many of my colleagues.

Americans live in the wealthiest, most powerful nation in the world and spend $2 trillion a year on health care every year—more than the next 10 countries combined—and many don’t have the best health care in the world. Thousands suffer and many die because of a lack of access to health care. Passing this bill and preserving its structure is a critical investment in the health of future generations.

Mr. Speaker, I rise today in objection to the Pelosi Health Care Bill which creates over $1 trillion in new government spending. It is funded with the “Hope” that our children will figure out how to pay the bill tomorrow and with a “Change” in the Medicare program that will cost $80 billion from the over 45 million beneficiaries currently covered.

Provisions within the Pelosi Health Reform Bill will raise premiums and lower access to care for America’s seniors. Although Democrats try to present these changes to Medicare as improvements and savings, the White House’s own actuaries have stated that these changes will increase Medicare spending at a greater rate than if we had done nothing at all. With the Centers for Medicare and Medicaid Services reporting earlier this year that the Medicare trust fund will be exhausted by the year 2017, I do not believe this Congress should take any action that hastens the jeopardy already faced by America’s seniors.

The Pelosi Health Care Bill cuts $170 billion from the Medicare Advantage Program, which covers almost 50 percent of the Medicare beneficiaries in the 44th Congressional District of California—36,124 senior citizens who rely on this highly successful program for their health care needs. The cuts undermine a program that currently gives seniors the choice to enroll in a private option and that provides the same enhanced benefits as traditional Medicare, pre-enroll in a private option and that provides the same benefits as traditional Medicare, pre-pay for prescription drug and other additional health benefits, usually with lower copayments.

The proposed changes also will result in reduced benefits for Medicare Advantage beneficiaries or result in higher premiums and copayments for fixed income seniors. But let me be clear—not for an improvement in service, but for the same or reduced level of service. For the workforce paying into the Medicare program, higher taxes are ahead.

In addition to the increased tax burden working Americans will face to keep Medicare afloat, this bill levies a 2.5 percent tax on the incomes of hardworking working Americans who cannot afford insurance. This breaks a fundamental promise of President Obama’s campaign that he would not raise taxes on the middle class.

And even as the national unemployment climbs above 10 percent nationwide—over 20 percent in some parts of my district—Speaker Pelosi wants to add a tax on small businesses which cannot afford to provide government mandated “acceptable insurance” to their employees. In this economic climate, Congress should be working to enact real reform across the United States that creates jobs and stimulates the economy, not enacting yet another government expansion and tax regime that will put the jobs of at least 5.5 million largely low wage earners, minorities and young people at risk.

Finally, while Americans struggle to pay their bills and put food on the table, Speaker Pelosi wants even more of their tax dollars to be spent to provide federal health benefits to the 12 million illegal immigrants currently in the United States. As I understand the bill before us today, a person would only need to declare that they are a citizen, provide a name and Social Security number and they would be eligible to receive health insurance benefits. There is no requirement for the verification of identification documentation. It is absolutely unacceptable that this bill would not, at a minimum, require even one verified method of verification to receive taxpayer funded health care benefits. The bill should include clear processes and require documentation to confirm that an individual applying for health care benefits is a citizen or legal resident of the United States like the E-Verify program I created in 1996 for employers to verify the legal status of new employees.

The crafting of the bill before us today spent American liberties to purchase House Demo- crat votes in order to secure a political victory. The resulting legislation has put freedom and American ingenuity under the knife. For the sake of American jobs, American families and future generations, we must kill this bill and resume our work to create jobs, rein in government spending, increase healthcare freedom and choice and getting the U.S. government’s financial house back in order.

However, I look forward to voting in favor of the Stupak-Pitts Amendment, which maintains the current federal government policy of preventing federal funding for abortion and for benefits packages that include abortion. This amendment ensures that federal taxpayers will not be coerced into funding elective abortions and is supported by U.S. Conference of Catholic Bishops, Democrats for Life, National Right to Life, Americans United for Life, Family Research Council, Concerned Women for America and many other pro-life groups. I look forward to continuing to work to ensure taxpayer funds are not used to fund abortions and to provide the broadest possible consciences protections for physicians, health professionals, hospitals, insurers, and all those in the business of caring for the health of Americans.

Mr. DICKS. Mr. Speaker, we have reached a pivotal moment in the House of Representa- tives today as we are about to approve the most significant expansion of access to health care in America in at least a generation. And the bill we are about to approve also represents the most substantial improvement of the quality of health care in our country that has been passed in the entire time I have been in Congress. I am proud to support this long-overdue and aptly-named legislation, the Affordable Health Care for America Act.

I am particularly pleased that we have come to an agreement within this bill on a provision that I believe will lead to a dramatic improvement in the way we care for America’s seniors under Medicare. Under the current Medicare payment system, providers are reimbursed on a “fee-for-service” system that encourages more procedures and office visits. One of the most important aspects of H.R. 3962 is language that will help shift Medicare to a system that is more efficient and that encourages better coordination of health care for seniors.

Medicare’s complex reimbursement formula has long punished doctors for providing more cost effective, quality health care. It is truly unfair under our current system that Medicare spends $7,363 per enrollee in a city in my district—Tacoma, Washington—while it spends twice that amount, $14,946, in the small Texas town of McAllen. These differences are largely due to discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other re sources—and a payment system that rewards more intense use of medical facilities and testing. But this focus on utilization is not only inherently more costly, it tends to igno re the health care outcomes, which should really be the goal of any system of care. And it exacerbates the problem we are already fac ing with Medicare: out-of-control growth rates. At current trajectory, Medicare will be $660 billion in the red by 2023, highlighting the urgent need to find ways to trim this growth rate. If we could reduce the annual growth in per capita Medicare spending from the national average—3.5 percent—to 2.4 percent, the rate in San Francisco, Medicare could save $1.42 trillion over that period and turn the deficit into a healthy surplus.

So in order to help move us toward this goal and produce a more equitable system of reimbursement, I was pleased to work with a number of concerned Members here in Congress on language in this bill that will enlist the resources of the independent, non-profit Institute of Medicine to examine the existing Medicare geographic payment inequities for both physicians and hospital payments and address the inequities that are clearly contained in our current system. We are also investing $4 billion per year in 2012 and 2013 to make pay ment rate adjustments so that no geographic area will be disadvantaged during 2012 and 2013.

I am also pleased that a related provision of this bill calls for an additional study by the Insti tute of Medicine to conceptualize a system of Medicare payments based on quality outcomes versus the current “fee-for-service.” This “High-Value Study” will be completed by April 15, 2011 and the Institute’s recommendations will be submitted to the Secretary of Health and Human Services, who will then have 240 days to submit a final imple mentation plan. This plan will take effect unless Congress passes a resolution of disapproval by the end of May 2012.

These are very important reforms that I believe will help ensure the solvency of Medicare and promote a more equitable system of health care for seniors over process. They are among the many as pects of this overall health care reform package that deserve our support, and I am proud
to be speaking today to recognize these provisions and to urge all my colleagues to pass the Affordable Health Care for America Act.

Mr. WALZ. Mr. Speaker, over the past three years, I've discussed health care reform with thousands of my constituents. I've heard from doctors and nurses, health care policy experts and small business owners. Most important, I've heard from middle-class Minnesotans who are fed up with the status quo.

Take Kristy, who is a Rochester mother and breast cancer survivor. Access to affordable health insurance is a life or death matter for her and millions of other Americans.

Last year, Kristy's health insurance premium increased 17 percent. Hard-working Americans every year see premiums rise faster than their take-home pay. This is a financial disaster in progress. If ignored, this will result in an explosion in the number of uninsured individuals, reaching far into the ranks of the gainfully employed and middle class.

Kristy's employer laid-off workers this year, in part because of rapidly rising health care costs. Small businesses across America are shedding good workers to cover sky-rocketing health care expenses, stifling entrepreneurship and innovation.

And then, recently, Kristy lost her job. She worries about whether she'll be able to get health insurance given her pre-existing medical conditions, since her temporary COBRA coverage expires.

Last year, more than 700 of our neighbors in southern Minnesota went bankrupt because of medical bills. It is unconscionable for any-one to go broke solely because they get sick. Now, they wonder if they'll be next.

Kristy's story has become all too common in America today. It doesn't have to be this way.

I rose today in strong support of H.R. 3962, the Affordable Health Care for America Act, because of people like Kristy. This bill, which includes important fixes from Democrats and Republicans, will tear down the status quo, rein in costs and bring stability and peace of mind to regular people like Kristy.

The House health care bill has four important pillars of reform:

The first pillar stops run-away costs and re-wards quality care. A patient-centered initiative spearheaded by Mayo Clinic is at the heart of rewarding quality. The current fee-for-service payment model in Medicare perversely encourages sky-rocketing health care expenses, stifling entrepreneurship and innovation.

And then, recently, Kristy lost her job. She worries about whether she’ll be able to get health insurance given her pre-existing medical conditions, since her temporary COBRA coverage expires.

Last year, more than 700 of our neighbors in southern Minnesota went bankrupt because of medical bills. It is unconscionable for any-one to go broke solely because they get sick. Now, they wonder if they’ll be next.

Kristy’s story has become all too common in America today. It doesn’t have to be this way.

I rose today in strong support of H.R. 3962, the Affordable Health Care for America Act, because of people like Kristy. This bill, which includes important fixes from Democrats and Republicans, will tear down the status quo, rein in costs and bring stability and peace of mind to regular people like Kristy.

The House health care bill has four important pillars of reform:

The first pillar stops run-away costs and re-wards quality care. A patient-centered initiative spearheaded by Mayo Clinic is at the heart of rewarding quality. The current fee-for-service payment model in Medicare perversely encourages sky-rocketing health care expenses, stifling entrepreneurship and innovation.

And then, recently, Kristy lost her job. She worries about whether she’ll be able to get health insurance given her pre-existing medical conditions, since her temporary COBRA coverage expires.

Last year, more than 700 of our neighbors in southern Minnesota went bankrupt because of medical bills. It is unconscionable for any-one to go broke solely because they get sick. Now, they wonder if they’ll be next.

Kristy’s story has become all too common in America today. It doesn’t have to be this way.

I rose today in strong support of H.R. 3962, the Affordable Health Care for America Act, because of people like Kristy. This bill, which includes important fixes from Democrats and Republicans, will tear down the status quo, rein in costs and bring stability and peace of mind to regular people like Kristy.

The House health care bill has four important pillars of reform:

The first pillar stops run-away costs and re-wards quality care. A patient-centered initiative spearheaded by Mayo Clinic is at the heart of rewarding quality. The current fee-for-service payment model in Medicare perversely encourages sky-rocketing health care expenses, stifling entrepreneurship and innovation.

And then, recently, Kristy lost her job. She worries about whether she’ll be able to get health insurance given her pre-existing medical conditions, since her temporary COBRA coverage expires.

Last year, more than 700 of our neighbors in southern Minnesota went bankrupt because of medical bills. It is unconscionable for any-one to go broke solely because they get sick. Now, they wonder if they’ll be next.

Kristy’s story has become all too common in America today. It doesn’t have to be this way.

I rose today in strong support of H.R. 3962, the Affordable Health Care for America Act, because of people like Kristy. This bill, which includes important fixes from Democrats and Republicans, will tear down the status quo, rein in costs and bring stability and peace of mind to regular people like Kristy.

The House health care bill has four important pillars of reform:

The first pillar stops run-away costs and re-wards quality care. A patient-centered initiative spearheaded by Mayo Clinic is at the heart of rewarding quality. The current fee-for-service payment model in Medicare perversely encourages sky-rocketing health care expenses, stifling entrepreneurship and innovation.
their premiums $5,000 lower than the cheapest government-run health insurance plan offered by the Democrats.

The Republican plan provides options for those with pre-existing conditions or those otherwise unable to afford health insurance through their employer. It also would allow people to access the full range of plans in the private market. The plan would ensure that all Americans have access to health insurance.

The plan also includes proposals to provide more choices and lower costs for consumers. It contains provisions to reduce the costs of health care and to promote innovation and competition in the health care market.

The plan would also provide funding for states to expand Medicaid and help states reduce their costs. It would also provide incentives for states to improve their health care delivery systems.

The plan also includes provisions to address the nation's aging population. It would provide funding for states to establish long-term care insurance programs and would also provide incentives for states to develop innovative models for long-term care.

The plan also includes provisions to protect the rights of patients and to promote transparency in the health care market. It would require hospitals and other health care providers to report information on their performance and to provide patients with access to information on the quality of care they receive.

The plan also includes provisions to reduce the federal deficit and to put the country on a fiscally sustainable path. It would reduce the deficit by $2.5 trillion over the next 10 years, including through reductions in health care spending.

In conclusion, the Republican plan is a comprehensive and balanced approach to reforming our health care system. It would provide the American people with more choices, lower costs, and greater access to quality care. It would also protect the rights of patients and would put the country on a fiscally sustainable path.

Ms. KAPTUR. Mr. Speaker, the Affordable Health Care Act will strengthen America and offer greater security to our workers, families, and our health care system.

The bill would reduce the deficit by over $2.5 trillion, including through reductions in health care spending. It would also provide incentives for states to improve their health care delivery systems.

In conclusion, the Affordable Health Care Act is a comprehensive and balanced approach to reforming our health care system. It would provide the American people with more choices, lower costs, and greater access to quality care. It would also protect the rights of patients and would put the country on a fiscally sustainable path.
With the mounting economic strain on American families and the rising costs of health insurance to workers, businesses and federal budget, the status quo has proven itself unsustainable, fiscally irresponsible and morally unacceptable. The time has come for this historical change. I stand in support of its promise to the American people.

Mr. KUCINICH. Mr. Speaker, we have been led to believe that we must make our health care choices only within the current structure of a predatory, for-profit insurance system which only continues providing health care. We cannot fail the insurance companies for being what they are. But we can fault legislation in which the government incentivizes the perpetuation, indeed the strengthening, of the for-profit health insurance industry, the very source of the problem. When health insurance companies deny care or raise premiums, co-pays and deductibles they are simply trying to make a profit. That is our system.

Clearly, the insurance companies are the problem, not the solution. They are driving up the cost of health care. Because their massive bureaucracy avoids having to fight insurance companies to avoid getting stuck with an unfair share of the bills. The result is that since 1970, the number of physicians has increased by less than 5%, while the number of administrators has increased by 3000%. It is no wonder that 31 cents of every health care dollar goes to administrative costs, not toward providing care. Even those with insurance are at risk. The single biggest cause of bankruptcy is medical bills so effective are they force hospitals and doctors to hire their own bureaucracy to fight the insurance companies to avoid getting stuck with an unfair share of the bills. But instead of working toward the elimination of for-profit insurance, H.R. 3962 would put the government in the role of accelerating the privatization of health care. In H.R. 3962, the government is requiring at least 21 million Americans to buy private health insurance from the very industry that causes costs to be so high, which will result in at least $70 billion in new annual revenue, much of which is coming from taxpayers. This inevitably will lead to even more coverage subsidies, and higher profits for insurance companies—a bailout under a blue cross.

By incurring only a new requirement to cover pre-existing conditions, a weakened public option, and a few other important but limited concessions, the health insurance companies are getting quite a deal. The Center for Public Integrity has reported, for example, a monopoly of competition to a single-payer industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administrators of Medicare and Medicaid. The Administration stated that the prospect of even greater fayers for insurance companies.

Today, we are faced with a historic opportunity to re-engineer our health care system. The changes we need to make are necessary to ensure that the health care system is sustainable. And as the President signaled that he is committed to this important goal, he is making the necessary changes to ensure that the health care system is sustainable.

If we pass this legislation, we will reduce the federal deficit by an estimated $129 billion over the next ten years. If we fail to do so, we will ensure that our country continues to spend $792,794 a second on healthcare. We will continue to dedicate 17.6 percent of our gross domestic product, or $3 trillion a year towards healthcare expenditures.

As a result, our healthcare system will be able to provide access to health care for all Americans, no longer will families fear the uncertainty of a catastrophic health event, or fear being driven into bankruptcy in trying to pay for the cost of care. No longer will people have to fear losing their health coverage simply for getting sick. In passing this legislation, we would be moving to a system where 140 million Americans lose their coverage every day.

The time has come when we, in Congress, have faced with a decision to either change the course of this country, to shift its direction toward accessible and affordable health care, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.

Mr. MARKEY. Mr. Speaker, I want to thank you Speaker PELOSI, Chairman WAXMAN, Chairman DINGELL, Chairman RANGEL and Chairman MILLER for your leadership in bringing us to this historic day.

For almost a century, we have been laying the groundwork to put our health insurance companies to work reform in our country—ever since Theodore Roosevelt's Progressive Party included health insurance coverage in its platform for the 1912 elections. Since then, there has been some progress—Medicare for seniors, Medicaid for the poor, CHIP for children,—as well as successful efforts in some states, including the landmark health reform law enacted in my home state of Massachusetts three years ago. But we have continued to come up short. And now the 46 million Americans without health care are paying the price.

Our health care system has been ailing for decades, and now it's in intensive care. The consequences of this broken health care system are severe—the cause of personal bankruptcies today is medical bills—Americans going broke when they get sick. And 80 percent of these medical bankruptcies strike Americans who actually have insurance. It is unconscionable that so many Americans have to fight their insurance companies while they fight for their lives. Their insurance policies fail to cover all of the astronomical costs associated with their treatments. They are insured, but not covered.

Historically, we have recently received a letter from a constituent that illustrates one of the reasons why we need health care reform now. Peter returned home from the hospital to find a bill informing him that his insurance company denied coverage for the anesthesia used during his operation. The insurance company deemed the anesthesia "medically unnecessary" and billed him $10,000. He had open heart surgery, Mr. Chairman. So he asked me, did the insurance company expect him to "take a swig of whiskey and bite it out" while the surgeon cut open his chest? Unbelievable, Mr. Chairman, but true.

Like too many Americans, he was insured, but not covered. We desperately need health care reform because there are too many stories like Peter's all across the country.

During the debate, when the interests of insurance companies would have been effectively challenged, that challenge was turned back. The "robust public option" which would have offered a modicum of competition to a monopolistic industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administrators of Medicare and Medicaid. The Administration stated that the prospect of even greater fayers for insurance companies.

The time has come when we, in Congress, are faced with a decision to either change the course of this country, to shift its direction toward accessible and affordable health care, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.

Mr. MARKEY. Mr. Speaker, I want to thank you Speaker PELOSI, Chairman WAXMAN, Chairman DINGELL, Chairman RANGEL and Chairman MILLER for your leadership in bringing us to this historic day.

For almost a century, we have been laying the groundwork to put our health insurance companies to work reform in our country—ever since Theodore Roosevelt's Progressive Party included health insurance coverage in its platform for the 1912 elections. Since then, there has been some progress—Medicare for seniors, Medicaid for the poor, CHIP for children,—as well as successful efforts in some states, including the landmark health reform law enacted in my home state of Massachusetts three years ago. But we have continued to come up short. And now the 46 million Americans without health care are paying the price.

Our health care system has been ailing for decades, and now it's in intensive care. The consequences of this broken health care system are severe—the cause of personal bankruptcies today is medical bills—Americans going broke when they get sick. And 80 percent of these medical bankruptcies strike Americans who actually have insurance. It is unconscionable that so many Americans have to fight their insurance companies while they fight for their lives. Their insurance policies fail to cover all of the astronomical costs associated with their treatments. They are insured, but not covered.

Historically, we have recently received a letter from a constituent that illustrates one of the reasons why we need health care reform now. Peter returned home from the hospital to find a bill informing him that his insurance company denied coverage for the anesthesia used during his operation. The insurance company deemed the anesthesia "medically unnecessary" and billed him $10,000. He had open heart surgery, Mr. Chairman. So he asked me, did the insurance company expect him to "take a swig of whiskey and bite it out" while the surgeon cut open his chest? Unbelievable, Mr. Chairman, but true.

Like too many Americans, he was insured, but not covered. We desperately need health care reform because there are too many stories like Peter's all across the country.

During the debate, when the interests of insurance companies would have been effectively challenged, that challenge was turned back. The "robust public option" which would have offered a modicum of competition to a monopolistic industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administrators of Medicare and Medicaid. The Administration stated that the prospect of even greater fayers for insurance companies.

The time has come when we, in Congress, are faced with a decision to either change the course of this country, to shift its direction toward accessible and affordable health care, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.

Mr. MARKEY. Mr. Speaker, I want to thank you Speaker PELOSI, Chairman WAXMAN, Chairman DINGELL, Chairman RANGEL and Chairman MILLER for your leadership in bringing us to this historic day.

For almost a century, we have been laying the groundwork to put our health insurance companies to work reform in our country—ever since Theodore Roosevelt's Progressive Party included health insurance coverage in its platform for the 1912 elections. Since then, there has been some progress—Medicare for seniors, Medicaid for the poor, CHIP for children,—as well as successful efforts in some states, including the landmark health reform law enacted in my home state of Massachusetts three years ago. But we have continued to come up short. And now the 46 million Americans without health care are paying the price.

Our health care system has been ailing for decades, and now it's in intensive care. The consequences of this broken health care system are severe—the cause of personal bankruptcies today is medical bills—Americans going broke when they get sick. And 80 percent of these medical bankruptcies strike Americans who actually have insurance. It is unconscionable that so many Americans have to fight their insurance companies while they fight for their lives. Their insurance policies fail to cover all of the astronomical costs associated with their treatments. They are insured, but not covered.

Historically, we have recently received a letter from a constituent that illustrates one of the reasons why we need health care reform now. Peter returned home from the hospital to find a bill informing him that his insurance company denied coverage for the anesthesia used during his operation. The insurance company deemed the anesthesia "medically unnecessary" and billed him $10,000. He had open heart surgery, Mr. Chairman. So he asked me, did the insurance company expect him to "take a swig of whiskey and bite it out" while the surgeon cut open his chest? Unbelievable, Mr. Chairman, but true.

Like too many Americans, he was insured, but not covered. We desperately need health care reform because there are too many stories like Pete's all across the country.

During the debate, when the interests of insurance companies would have been effectively challenged, that challenge was turned back. The "robust public option" which would have offered a modicum of competition to a monopolistic industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administrators of Medicare and Medicaid. The Administration stated that the prospect of even greater fayers for insurance companies.

The time has come when we, in Congress, are faced with a decision to either change the course of this country, to shift its direction toward accessible and affordable health care, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.
We support RESEARCH, building on the $10.4 billion down payment in the recovery and reinvestment act for NIH. In this bill, we will invest in comparative effectiveness research to help improve the quality of care and reduce costs.

The House bill's approach is really quite simple: You're On Your Own. The Republican plan tells Americans—if you get sick and don't have insurance, you're on your own. The Republican plan tells Americans if you are denied coverage because of a pre-existing condition “You're on your own.” Republican Leaders in Washington seem to be suffering from a pre-existing condition of their own—a heart of stone. If you kicked their heart, you'd break your toe! And under the Republican plan, they could be denied coverage.

The Republicans say the Democratic Plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill, not the Republican Plan. They say it will hurt small businesses but the Main Street Alliance, representing thousands of small businesses around the country, support the Democratic bill, not the Republican Plan. The Republicans claim the Democratic bill will hurt seniors, but the AARP has endorsed the Democratic bill, not the Republican Plan.

There are reasons why the AARP supports the Democratic Plan. The Democratic bill will close the Medicare part D donut hole, the Republican bill does not. We provide support for low-income seniors, they do not. We will extend the solvency of Medicare, they do not. You know, GOP used to stand for Grand Old Party, it stands for Grandstand, Oppose, and Pretend. They grandstand withphony claims about non-existent death panels. They oppose any real reform. And with this phony claims about non-existent death panels. Together with the nine sovereign Native Tribes I represent, I have worked hard to advance the Indian Health Care reauthorization in the House of Representatives. I share the concerns of the Great Plains Tribal Chairs Association (GPTCA) regarding aspects of the current version of that legislation. The GPTCA is comprised by the elected leaders of the sovereign Indian Tribes and Nations of the Great Plains, including South Dakota. I have consulted closely with the Tribes I represent. For years, the Tribes and the GPTCA have supported the Indian Health reauthorization and have been disappointed at the great length of time it has taken to bring the legislation to this point in the House. The GPTCA has reviewed the current version of the Indian Health Care reauthorization contained in the broader health reform bill and has serious concerns about certain provisions in the bill, principally the fact that urban Indian non-profit organizations are, in various sections outside of Title V of the reauthorization, treated on a par with federally-recognized tribes.

The federal government has a unique relationship with the 562 federally-recognized American Indian and Alaska Native tribes. This government-to-government relationship is established by our founders in the U.S. Constitution, recognized through treaties, and reaffirmed through executive orders, judicial decisions, and congressional action. Fundamentally, this relationship establishes the responsibilities to be carried out by one sovereign to the other. That is why these requests by nine sovereign Sioux tribes located in South Dakota are essential. I will continue to provide my full support to GPTCA's requests to improve the reauthorization in Congress with the Senate, and to properly fund Indian health services.

Turning again to the broader House health care reform bill, underlying my concerns relating to Medicare and long-term care and other issues is a fundamental concern about the effect of broader House health care reform bill...
November 7, 2009

I wish this was the day that the majority in Congress sat up and listened to the American people... not just the tens of thousands that stood at the steps of our Capitol to speak out in defense of protecting their health care... but the millions from around the country who called our offices, wrote letters to their newspapers, spoke at town hall meetings... or marched on Washington.

If they did, they would hear their deep and abiding concern for what will happen to their health care if this bill passes. What will happen to seniors, and everyone taking care of their elderly parents or in-laws, when the overpromise of “free health care” meets the economic reality of “rationed care” when the federal government runs short on money?

What happens to Medicare Advantage customers whose services will be cut? What happens to those using Health Savings Accounts whose health freedoms will be infringed upon?

What happens to the small business owner who desperately wants to hire back some employees or expand his business to provide more economic opportunities in his community? What happens when these individuals, upon whose success our nation will rise from this recession, have to pay the hundreds of billions in new taxes to pay for the massive government expansion in this bill?

Mr. Speaker, how bad does it have to get? How bad does it have to get before this Congress starts acting in a way that will help families, create jobs, and make America a better America for our children and grandchildren?

How bad does unemployment have to get? Earlier this week, it was announced that our nation has reached an unemployment rate of 10.2 percent, which is the highest unemployment rate in almost 30 years. Yet studies suggest that the taxes, mandates, and federal expansion in this bill will cost our nation another 5.5 million jobs in the private sector.

How bad does the deficit have to get? This year’s deficit of over 1 trillion dollars was the highest in history. Yet this multi-trillion-dollar expenditure to take over the nation’s health care system will explode the deficit, despite the fuzzy math that we’ve heard from the other side of the aisle.

The debt... it has reached a nearly insurmountable level of 12 trillion dollars. How bad does it have to get? Even without the massive uncontrolled expenditures involved with this health care bill, the national debt is projected to surpass the size of our economy in the next few years. Since when has the answer to an explosive expansion of federal government spending in areas that have always been a part of the private sector economy?

The one positive thing I can say about this bill is the pro-life victory we won with the Chairman Rangel of the Education and Labor Committee, Chairman Miller of the Energy and Commerce Committee, and Chairman Waxman of the Energy and Commerce Committee.

I wish it was an historic day!
necessary albeit difficult steps to rein in the escalating costs of health care in this country. I will vote for H.R. 3962 for many reasons. The most important is that it will provide access to affordable health care to the millions of uninsured individuals in this country. In my 34th Congressional District of California, where the average annual household income is less than $36,000, and where forty percent of my constituents are currently uninsured, this bill will provide access to health care for 240,000 more people.

The bill also benefits families in our country who have health insurance, but are struggling with high premiums and uncovered health care costs. Last year, 1,120 families in my district were forced to file health care-related bankruptcies. H.R. 3962 will protect individuals like them from catastrophic out of pocket costs through an annual allowable personal expense cap. This bill will protect our seniors from the Medicare Part D donut hole by reducing 5 percent of the cost for brand name drugs and gradually eliminating the donut hole altogether. This would be extremely beneficial for the 4,100 seniors in my district who each year hit the Medicare Part D donut hole requiring them to pay the full cost of medications they can’t afford.

H.R. 3962 will help make small businesses more competitive in providing health insurance to their employees by providing tax credits up to 50 percent of the cost of the insurance. In my district approximately 15,000 small businesses would qualify for these credits.

As chair of the Congressional Hispanic Caucus Health Task Force, I commend the Affordable Health Care for America Act for its efforts to reduce health disparities and improve minority access to culturally and linguistically competent health care. The bill expands Community Health Centers which have been a cornerstone of primary care services in communities of color, and incorporates critical health disparities language guided by the Health Equity and Accountability Act of 2009. In addition, the Manager’s Amendment strengthens the focus of eliminating health disparities by codifying the Office of Minority Health and establishing Minority Health Offices across all Department of Health and Human Services agencies.

As co-chair of the Congressional Study Group on Public Health, I am particularly pleased that the Affordable Health Care for America Act finally prioritizes prevention and public health in this country. The bill ensures full coverage of evidence based preventive health services, and establishes a Public Health Investment Fund that will support core public health infrastructure, help finance the delivery of evidence based prevention and wellness services, and provide grants to train the next generation of Public Health workforce professionals.

Mr. Speaker, I fully believe that the Affordable Health Care for America Act is a bill that will transform our healthcare system and will play a determining role in the collective health and fiscal viability of our region, our state, and our nation. I urge my colleagues to join me in voting yes for this bill today, to ensure that our families and communities will have the promise of a healthier tomorrow.

Mr. VAN HOLLEN. Mr. Speaker, we are taking a historic and very important step today to lower health care costs for American families and small businesses, and fix a broken health care system.

In considering the Affordable Health Care for America Act, this has been one of the most open and transparent debates in Congress. There have been over 100 hearings and mark-ups and more than 3,000 public health care events around the country.

The Affordable Health Care for America Act contains significant protections that will provide health care consumers greater stability, lower costs, and improved quality—while all at the same time paying down the deficit. According to independent analysis conducted by the non-partisan Congressional Budget Office, the bill reduces the deficit by $109 billion over the first 10 years. And it will continue to reduce the deficit over the second 10 years.

This legislation will help the middle class by providing stable, affordable health insurance that people can count on. It will rein in health care costs for families, businesses and the government. It will ensure that if you lose your job, you won’t lose health care. No one should have to worry about whether they can see a doctor when they’re sick because they don’t have health insurance.

I have heard from countless constituents who have been victims of discrimination by insurers, and how the family who recently shared their experience with me about their inability to obtain health insurance coverage. The father started his own company and applied for health insurance for his family, but three out of the four family members could not be fully covered due to pre-existing conditions. It turns out they were rejected for coverage because he had two chest colds in the last 6 years and scar tissue in his lungs. For his daughter, the insurance company would only issue a policy that precluded coverage for any injury to her back at any time in the future because of a previous injury of her back. And the same company refused to cover any injury to his son’s knee at any time in the future from any cause due to a previous injury. It is unconscionable that the insurance company’s policies precluded everyone in his family from obtaining coverage.

There are a number of provisions that would help this family, my constituents, and millions of Americans. Among them, the bill would end the practice of discriminating against those with pre-existing conditions, such as diabetes, cancer, a heart condition, or previous injuries. It would prohibit insurance companies from dropping health care coverage because you became sick. The bill eliminates co-pays for preventive and wellness care, and it places annual caps on what Americans pay out-of-pocket for health care services. And there would be no yearly or lifetime cost caps on what insurance companies cover.

A critical piece of this legislation is the creation of a new Health Insurance Exchange that will allow individuals and small business to comparison shop for affordable and quality health insurance coverage. The Exchange will help reduce the growth in health care spending by encouraging competition on price, quality, and transparency among a number of private health insurance companies and a public health insurance option. The public option will compete in the market and will require that participation is completely voluntary. That is why Consumers Union and Consumer Reports endorsed this bill. With this health care reform bill, Americans will have the freedom to keep their doctor or select another one.

The legislation takes steps to preserve and strengthen Medicare for today’s seniors and future generations of retirees. For over 40 years, Medicare has been a stable, reliable program for senior citizens and people with disabilities. It provides health care to an estimated 45 million Americans. This bill will ensure that seniors can see their doctor of choice or find a doctor by improving Medicare reimbursement to doctors. It lowers drug costs for seniors by closing the Medicare Part D “doughnut hole” and allowing the government to negotiate with pharmaceutical companies for lower drug prices. And it takes steps to reduce waste, fraud, abuse, and inefficiency in the Medicare program. For all these reasons, AARP has endorsed this bill.

Thousands of small businesses in America will benefit from this bill because it will provide them greater affordability. Small businesses will gain access to the new Health Insurance Exchange that will allow them to obtain rates normally enjoyed by larger employers, lower administrative costs, greater transparency, and choice of plans.

They will benefit from increased competition for better prices as well as tax credits for those who choose to provide health insurance for their employees.

I am pleased that this bill contains several provisions I helped author. The first, the Assessment of Medicare Cost-Intensive Diseases and Conditions, directs the Department of Health and Human Services to conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program. Part of our effort to reform the health care system is to develop cures and treatments for those conditions and diseases that have a high cost, and this will go a long way in that endeavor.

The second, which I worked on with Representatives KATHY DAHLKEMPER and others, requires health insurance plans to allow young people through age 26 to remain on their parents’ insurance policy, at the parent’s choice. Young adults between the ages of 19 and 29 are one of the largest segments of the American population without health insurance, comprising 29 percent of the total number of uninsured Americans.

I am also pleased that we were able to include a provision that ends the special advantages for health insurance companies. For far too long, the health insurance industry has been exempt from the antitrust laws that govern most other businesses. They have abused that benefit. I believe it is long past time to repeal this exemption. By ending this antitrust exemption, we are increasing competition and preventing unfair business practices that allow health insurers to drive up the cost of health care.

Lastly, I worked with Representatives HIMES, BEAN, and others to include in the bill a provision that would allow the creation of state health insurance compacts. This would permit states to enter into agreements to allow for the sale of health insurance across state lines. The creation of state health insurance compacts is another element of the health reform
bill that will allow consumers to shop for insurance across state lines, promote choice and competition, and ensure strong consumer protections.

On the question of whether any of the insurance plans offered in the Health Insurance Exchange could cover abortion, I support the amendment offered by Representative STUPAK goes much further. It would effectively prevent Americans from using their own money to purchase an insurance plan in the Health Insurance Exchange that includes coverage of abortion. That would be a dramatic break with the current practice where most insurance plans provide for such coverage for individuals who choose such plans. Because the Stupak amendment would effectively prohibit individuals from using their own money to purchase such plans in the Exchange, I oppose it.

Mr. Speaker, today we stand at a historic crossroads. We can choose the road that dead-ends in the status quo—where the health insurance industry continues to call the shots and ration our health care—or we can pass this bill and take the path that leads to a future where every American has access to affordable, quality health care.

Now I understand why the health industry is opposed. But our job is not to protect the profits of the insurance companies. Let's not protect special interests and the status quo. Let's move America forward. Let's vote yes for America.

Ms. CORRINE BROWN of Florida. Mr. Speaker, like the majority of Americans, I am well aware of the desperate need in our country for comprehensive health care reform. In fact, the immediate need for reform became crystal clear to me when, over the August district trict period, I went to a hospital in Jacksonville to visit a friend. This friend, who had worked in the Duval County school system for over 25 years, was without health insurance, was struggling to support himself, and had no idea how he was going to be able to pay the hospital bill. For many, the many Americans who find themselves in similar situations: for the woman who cannot get insurance coverage because she is diabetic and has a pre-existing condition, to the one in nine children in America without health care, to the millions of middle class American citizens who skip necessary treatments because they cannot afford it, it is for them that the Affordable Healthcare for America Act, which will ensure that all Americans are covered and have access to affordable care, is necessary.

Unfortunately, the bill passed the House without any Republican support. Although many pieces of legislation this session have advanced in a bipartisan manner, particularly in my committees of specialization, Veterans Affairs and Transportation, health care has not been an issue of biparty agreement. In 2003, the Republican Party pushed through a horrible Medicare Prescription drug law that was voted along party lines, in which the Republicans voted for the law, I supported it which there is a wide gap in coverage that forces the co-payer to pay for much of their own prescription drug costs. Fortunately, the
care because premiums have increased more than 90 percent in the last nine years for Minnesota families. Our health care system is broken when our country spends $2.4 trillion a year for health care—almost twice as much per person as any other country—but we rank 37th in the world in health care outcomes.

Our health care system is broken when you can be denied coverage for being sick, for having a baby, or for suffering from domestic violence. Our health care system is broken when 45,000 people die in the United States each year because they lack health insurance and cannot access needed care.

We can and must do better. Today we have an opportunity to save these lives and make affordable health care insurance a reality for every American. My constituents and all citizens across this country need to know what is in this bill to help American families and workers. This legislation will make quality health care more affordable and more accessible for every patient. It will protect families from falling into bankruptcy due to unaffordable costs by limiting out-of-pocket costs, lifting lifetime limits on coverage, and capping premiums.

First and foremost, if you love your doctor and like your current insurance, you are free to keep what you have. This legislation does not require you to make any changes. Yet, the ranks of the insured are shrinking more every year and the numbers of satisfied citizens are falling. Millions of Americans have too little insurance, too few choices, and no options left. For those Americans—for most Americans—this legislation is a lifeline to the security they have longed for and deserved.

For every American the peace of mind that insurance companies can no longer deny coverage for pre-existing conditions, or cancel your coverage when you are sick and need it the most.

It is a commonsense and public insurance option to guarantee that Americans will have an affordable choice among insurance providers and keep private insurers honest. It improves health care for patients and their families by making investments to increase the number of providers, improve access to primary care, and support a patient-centered approach that focuses on quality and emphasizes prevention.

For our seniors, this legislation will strengthen Medicare by eliminating the waste, fraud and abuse that diverts health care dollars away from care and into the pockets of crooked companies. It will immediately begin closing the “donut hole” in the Medicare prescription drug benefit to make prescriptions more affordable. And it will ensure the financial stability and solvency of Medicare for 45 million seniors.

For our children, it will help expand coverage and ensure that the youngest Americans receive quality coverage that includes essential benefits such as vision and oral services. And it will extend coverage for young people by allowing them to remain on their parent’s insurance until their 27th birthday.

The Affordable Health Care for America Act does all these things while meeting President Obama’s call for new costs to be covered. In fact, the $2.4 trillion in costs we are working to improve the bill before it returns to the House for a final vote. To be truly comprehensive, health care reform legislation must reach all Americans, including the 15 million citizens employed in the nonprofit sector. Achieving parity between small nonprofit and for-profit employers in this legislation is one step in solving the health care costs over the long-term, and will help secure a better future for our patients, families, and seniors.

While the legislation we vote on today would have on patients, workers, and small businesses. I look forward to working with House Leadership and the conference committee to help address these issues and strengthen this legislation.

Still, H.R. 3962 remains a historic achievement. This legislation would provide health care to 15 million Minnesota’s families and families across this country. It modernizes Medicare and covers the uninsured. It invests in prevention instead of paying for disease. For these reasons and many more, the Affordable Health Care for America Act has the support of over 300 state and local organizations. Leaders include the American Nurses Association, American Medical Association, SEIU, AFL-CIO, and AARP. Organizations representing millions of Americans back this legislation because they know our health care system is broken and change cannot wait another year.

Still, there are critics of health care reform that are fighting desperately to maintain the status quo. It is disappointing to see Republicans who have offered no solutions to our broken system. They have offered politics and posturing but no real solutions. They have no serious alternative to H.R. 3962 to control costs, expand access and improve quality. They have made killing health reform and killing America’s chance at affordable health care reform their only goal. The American people deserve better.

I would like to thank Speaker Pelosi, Majority Leader HOYER, Majority Whip CLYBURN and Caucus Chair LARSON for their extraordinary leadership to bring affordable, quality health care to all Americans. Thanks are owed to the three committee chairmen—Chairman WAXMAN, Chairman RANGEL, and Chairman MILER—who held dozens of hearings throughout the year and crafted a historic bill. I would also like to thank Chairman DINGELL for his dedicated service in introducing health care legislation for over 50 years to bring health care coverage for all Americans.

I would especially like to thank Speaker PELOSI for her attention to the concerns of the Quality Care Coalition and all of the diverse interests of the Caucus. Vice Chairman BECERRA also has my gratitude for the vital role he played in negotiating this agreement to move health care reform toward high quality, cost-effective care.

Today is a historic step toward making health care reform a reality, but it is not the end. I urge the Senate to stay focused and committed so an equally strong bill meets H.R. 3962 in conference committee. I am committed to sending a health care bill to the President’s desk that will bring meaningful reform for American families, seniors and businesses. With passage of this historic legislation, health care will no longer be a privilege for those who can afford it.

I urge my colleagues to support H.R. 3962 and guarantee that affordable, quality health care will be accessible for every Minnesota family.

Mr. MCCAUL. Mr. Speaker, in the 72 hours we were allowed, Republicans wasted through thousands of pages of bureaucratic provisions, mandates, programs and spending. Despite its monstrous size, this health care takeover has come down to a few clear, evident points: it raises taxes, raises premiums, increases health care costs, and dumps trillions of dollars of debt on our children and
grandchildren. Small businesses and families will bear the weight of this bill for generations.

We all agree that health care reform is urgently needed, but this bill destroys the American health care system as opposed to improving it. Instead of incentivizing the private market, it offers more affordable health care coverage options. It punishes small businesses and their employees. It threatens jail time for individuals who do not purchase insurance and could soon lead to the rationing of care, depriving Americans of life-saving treatments that are not deemed “cost-effective.”

For those most experienced in this health care debate, oppose this proposal and have shared concerns of the many clinics and hospitals that will be forced to reduce or deny services.

The over 2,000 page spending plan imposes nearly $800 billion in new taxes on individuals, families and small businesses. It places mandates on both individuals and employers which, according to the President’s Economic Advisor, will result in the loss of up to 5.5 million jobs. These mandates will also impose nearly $800 billion in new taxes on individuals and employers, its deep cuts to Medicare, and the strong likelihood that H.R. 3962 consists of approximately 2,000 pages and costs more than $1 trillion over ten years. If adopted, this legislation for numerous substantive reasons, including my concerns about its trillion dollar plus cost to taxpayers, its mandates on individuals and employers, its deep cuts to Medicare, and the strong likelihood that H.R. 3962 consists of approximately 2,000 pages and costs more than $1 trillion over ten years. If adopted, this legislation will destroy millions of jobs by raising taxes on small businesses and other employers. H.R. 3962 also imposes new taxes on certain employer-provided health benefits and on medical devices such as wheelchairs and walkers. In total, H.R. 3962 includes more than $700 billion in new taxes.

Unbelievably, in the name of health care reform, H.R. 3962 cuts Medicare benefits by more than $400 billion and raises Medicare premiums, making access to comprehensive health care for all Americans for the first time in our Nation’s senior citizens. Additionally, over time, H.R. 3962 will move countless Americans involuntarily from private health insurance to government-run health care.

I have long maintained that there is no “silver bullet” for health care reform. We should aim to build upon the current health care system in a variety of ways, making health insurance more affordable and more accessible. In other words, Congress should fix what is broken in our nation’s health care system and be certain not to break what is not.

Congress should adopt insurance reforms to end the practice of denying coverage due to pre-existing conditions and ensure the portability of one’s health insurance. Additionally, Congress should allow small businesses to band together to negotiate insurance coverage for their employees, just as large corporations and labor unions are already allowed to do. Congress should also allow individuals to purchase health insurance across state lines from a competitive, nation-wide market and should allow for more options, choice, and innovation in the health care system.

The non-partisan Congressional Budget Office has estimated that average premiums under the Republican alternative would be almost $5,000 less than under the Democratic plan in 2016. It would provide incentive grants for states to further lower premiums, and allow businesses to innovate ways to promote health and wellness and curb health care spending. The alternative would also expand high risk pools, prohibit insurance companies from denying individuals with pre-existing conditions and guaranteeing purchasing of health insurance. These reforms would drive down the costs of health care to make it more affordable for Americans while also protecting the choice and numerous options that citizens need.

I have spoken to many health care professionals in my District as well as held town halls with my constituents, and both have expressed not only their opposition, but their fear, of this government takeover of health care. We are not listening to Americans, and we are missing the opportunity to use insight from the experts in the field to enact meaningful reform. This bill is not what Americans have asked for.

Mr. PLATTS. Mr. Speaker, I rise today in opposition to Speaker NANCY PELOSI’s health care plans (H.R. 3962) I plan to vote against this legislation for numerous substantive reasons, including my concerns about its trillion dollar plus cost to taxpayers, its mandates on individuals and employers, its deep cuts to Medicare, and the strong likelihood that H.R. 3962 would destroy the American health care system. W. Jay H. R. 3962 is a health care bill that fails to abide by the physician’s guiding principle: “First, do no harm.”

H.R. 3962 consists of approximately 2,000 pages and costs more than $1 trillion over ten years. If adopted, this legislation will destroy millions of jobs by raising taxes on small businesses and other employers. H.R. 3962 also imposes new taxes on certain employer-provided health benefits and on medical devices such as wheelchairs and walkers. In total, H.R. 3962 includes more than $700 billion in new taxes.

I worked to make sure this bill bars insurance companies from charging women more for their health care when they need it.

I worked to make sure this bill bars insurance companies from charging women more just because they are women.

I worked to make sure that this bill creates Collaborative Care Networks, to ensure that doctors, hospitals, and other health care providers work together to provide working families, lower income Americans, and those with chronic conditions the high quality coordinated care they need to stay healthy and out of emergency rooms.

I urge my colleagues on both sides of the aisle to vote for children and families by supporting this bill.

Mr. KANJORSKI. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act.
The House has taken an important first step today to improve the affordability and accessibility of health care. While today’s health care legislation is not perfect, action to address this important issue is absolutely necessary. If we do nothing to reform health care, health care costs are expected to double over the next ten years, just as they have over the last ten years.

Insured Americans pay on average $500 per year just to administer health insurance, more than double the administrative costs paid in any country which has a government-run health care system. The McKinsey Global Institute estimates that $91 billion a year is wasted on excessive insurance administrative costs.

Because about 60 percent of all Americans under the age of 65 receive insurance through their employers, much of this waste is burdening American companies. American companies competing in the global economy cannot afford this economic disadvantage. The bill we voted on today attempts to reduce the costs of insurance to employers and employees by providing greater competition among insurers. According to a study by the Massachusetts Institute of Technology, a family of four would save $1,260 in annual health insurance premiums if this bill is enacted.

It is estimated that 96 percent of all Americans will have access to affordable health insurance under this bill. While I believe that caring for our fellow citizens is a moral imperative, it also makes economic sense to have as many people covered by insurance as possible. Families USA estimates that every insured American family pays over $1,000 per year in premiums just to cover the medical expenses of the uninsured, who obtain urgently needed health care through inefficient means such as visits to hospital emergency rooms. As we face the threat of pandemics such as the current swine flu, it is in the best interest of all of our health to make sure that sick people are treated quickly and affordably so that infectious diseases are not spread.

What was the Democrat response to their many detailed provisions in this complex legislation? It is important to note what the bill does not do. The only effect it will have on senior citizens who rely on Medicare is it will reduce their out-of-pocket costs for prescription drugs by a number supported by AARP in its recent endorsement of the bill. The bill does not use tax dollars to pay for abortions. It does not require our smallest businesses to pay for insurance coverage for their employees. It will not result in the federal government controlling the delivery of health care; in fact, the bipartisan Congressional Budget Office (CBO) estimates that only six million Americans will choose to enroll in the government-sponsored insurance plan, the so-called “public option.” It does not add to the federal deficit. CBO estimates that the bill will reduce the deficit by $109 billion over the first ten years.

Finally, I want to praise the House leadership for including in this bill a provision which will help to fund the education of the next generation of doctors, some of whom I hope will be educated by our region’s own medical college.

We all share the goal of keeping American citizens healthy in the most humane and efficient means possible. I believe this bill is a reasonable first step toward reaching this goal. In closing, I appreciate the opportunity to share my thoughts about this important legislation.

Mr. TIAHRT. Mr. Speaker, I rise in strong opposition to H.R. 3962. I cannot and will not support this government takeover of our health care system that will restrict choice, ration care, increase the cost of health care, greatly increase government spending, and lead to the destruction of the world’s best medical care.

Amercians are fed up with Washington’s out of control spending, with more and more power over their daily lives being put in the hands of nameless, unaccountable bureaucrats, and with the systematic shift of the United States Government away from a limited government OF the people to a government FOR the people. The growing discontent began with the bloated stimulus bill that did nothing but grow a bigger Washington and create more bureaucratic jobs. It increased with the government takeover of General Motors, the cap and tax bill, the placement of power in the hands of unconfirmed and unconstitutional czars, and the grossly inflated spending bills passed for fiscal year 2010. With the Democrat attempt to takeover health care, the discontent has now come to a full boil.

This spring, summer and fall the American people have spoken loudly and clearly about what they do and do not want in health care reform. The Democrats ignored these sentiments and introduced H.R. 3200 and the two subsequent effective, livable, spirted town halls in my 15 years in Congress, followed by an unprecedented number of phone calls, emails and letters sent to my office by concerned Kansans.

The American people told us what they do and do not want. If we do not want a government takeover of health care, the American people do not want higher taxes, the American people do very much want to keep their health insurance and increase their choices and access for those who do not have insurance.

What was the Democrat response to their constituents? A new, bigger bill that again ignores the input of the American people and is even worse than H.R. 3200.

The new bill is a government takeover of health care. H.R. 3962 is double the original H.R. 3200 and reloaded with new mandates. The word “shall” appears 3,425 times—in other words—this is the government telling you to do something. The bill creates 118 new bureaucracies. The Congressional Budget Office (CBO) calculated the cost of the bill at $1.2 trillion but this does not include 28 instances of hidden costs indicated by the ominous words indicating that certain programs be appropriated “such sums as may be necessary.” The bill raises taxes, on individuals and job creators, including a $461 billion surcharge on small businesses according to the U.S. Chamber of Commerce. The Pelosi bill will result in 5.5 million job losses at a time when unemployment is already over 10 percent. And to top all of that off—this bill completely rewrites 19th of our nation’s economy. H.R. 3962 cuts benefits to seniors, does not ensure that Americans can keep their health insurance, limits choice, covers even more illegal immigrants than H.R. 3200 (2.5 million more according to CRS), and allows for taxpayer funded abortions.

If H.R. 3962 is enacted into law, even the Democrats acknowledge that health care costs will increase. As P.J. O’Rourke said, “If you think health care is expensive now, wait until you see what it costs when it’s free.”

My biggest concern with the Democrat proposals is the intended rationing of health care. The Obama administration has already begun to set the framework for rationed care with comparative effectiveness research. This is a very dangerous road to travel down. In addition to the Democrats, I am also opposed to the BAUCUS and PELOSI attempt to destroy Health Savings Accounts (HSAs). HSAs are what we should be promoting as a way to expand choice, give patients more control over their medical spending, and reduce health care costs. I want health care reform and am saddened that this process has become so political that we won’t see the much needed modernization that will ensure Americans have access to the best health care for decades to come. I am saddened that states like my home state of Kansas are forced to take drastic action to try to protect their citizens from being affected by Washington’s takeover of health care.

Republicans have offered better solutions and principles that should be included in any health care reform. Those principles should: let Americans who like their health coverage keep it, give all Americans the freedom to choose the health plan that best meets their needs; ensure that medical decisions are made by patients and their doctors, not government bureaucrats; and improve Americans’ health through effective, livable, spirited and disease management programs, while developing new treatments and cures for life-threatening diseases.

The Republican 219 page bill is a plan that lowers cost and improves health care access. This bill includes: incentives: Association Healthcare Options to let Americans group together for greater purchasing power; limitations on defensive medicine and implementing comprehensive medical liability reform; tackling waste, fraud and abuse (a $10 Billion annual cost to taxpayers generated from Medicare alone); and incentives for savings and increased use of personal Health Savings Accounts (HSAs). In addition, the Republican plan will ensure that Americans are not prevented from health coverage due to pre-existing conditions that have not subject to lifetime caps on treatment. Unlike the PELOSI and Obama plans, the Republican plan protects Medicare for seniors. Finally, the Republican plan protects taxpayers from funding abortions or health insurance for illegal immigrants. The Congressional Budget Office has confirmed that the Republican bill will lower premiums for the American people by up to 10 percent. Under our plan, premiums for families and small businesses would be nearly $5,000 per year lower.

I strongly encourage my colleagues to vote for the Republican substitute that will provide real solutions that will meet the needs of the American people. Our constituents have spoken loudly and clearly and it is our duty as their representatives to listen to them, not ignore them and use the sacred Speaker’s gavel to impose personal political goals upon them.

Mr. FILNER. Mr. Speaker, many Members of the House of Representatives have spoken at length on the ways that the Affordable Health Care Act will improve health care for all of our constituents. I wanted to draw attention to another significant benefit of this legislation: the creation of new high-paying jobs in this country. Let me repeat that...
for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. The millions of Americans with serious chronic conditions account for 40 percent of our healthcare spending. We are considering today how to improve the quality and cost of care patients receive by eliminating costly procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchangeable with an innovator’s product. This research will create high quality and high paying jobs and it is important that we keep this research in this country, and these jobs in this country. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of Health and Human Services and colleagues in Congress to ensure that these important research and manufacturing jobs stay right here in the United States.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New technology will help reduce costs and demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will create jobs in hardware production, software engineering and roundtable discussions, I can say that Americans, families, health care providers, business owners and other groups. What everyone can agree on is that our health care system is broken and needs attention. At the simplest level, we need to put an emphasis on preventive medicine. As the old saying goes, an ounce of prevention is worth a pound of cure. We treat too many people in emergency rooms instead of doctors’ offices, and often when they are sickest and care is the most expensive. H.R. 3962 moves us toward preventive care in a variety of ways, but chiefly through providing incentives for preventive care. We will treat millions more Americans. Having insurance will allow them to see a doctor on a regular basis and detect health problems earlier.

Most importantly today, passing H.R. 3962 keeps the process of health care reform moving forward. Today is a very important step, but there is still a long way to go. As we all know, the Senate is working on its version of health care reform legislation, and that bill is likely to be very different from this one, but I am confident we can craft a final product that incorporates the good ideas and makes our health care system better.

Mr. Speaker, I am glad that we slowed our process down and took some additional time before bringing it to the floor. This is not a perfect bill, but I think it is a positive difference for the entire country. Over 300 organizations have endorsed it, including AARP, the American Heart Association and the American Medical Association. I urge my colleagues to vote for H.R. 3962, and keep us moving towards a healthier America.

Ms. LINDA T. SANCHEZ of California. Mr. Speaker, I strongly support H.R. 3962, the Affordable Health Care for America Act, which delivers on a promise Americans have been waiting for since the New Deal, a promise that every family, no matter what their finances, no matter what their need, when they need it, without facing economic ruin.

I have previously spoken about the ways that this bill will help ensure access to affordable, high quality health care for American families. But another significant benefit of this legislation which has not received much attention is its promotion of high-paying research, high tech, and manufacturing jobs.

Contrary to the claims that this is a “job killing bill,” in fact this bill will create thousands of jobs here in the United States.

First, this bill will increase demand for healthcare workers, including doctors, nurses, nurse practitioners, physician assistants, home health workers, and more. More affordable insurance means more families getting the primary and chronic care they need instead of waiting until they need an emergency room. And it means more middle class American jobs that can’t be exported.

Second, this bill will continue the investments begun in the American Recovery and Reinvestment Act, also known as the stimulus bill, to expand the use of health information technology.

Health IT will help better manage the quality and cost of care patients receive by eliminating duplicate tests and ensuring that patients don’t receive the wrong medicine or the wrong dose. And investment in health IT creates jobs—jobs in hardware production, software design, and computer training. When we invest in quality health care for all Americans, we are investing in jobs.

Finally, this bill will promote more of what America already does so well: medical research. By allowing more Americans access to health insurance, this bill will increase the demand for advanced medical technologies that are manufactured right here in America.

And by creating a process for the Food and Drug Administration to approve so-called “biosimilars,” this bill will encourage competition in the cutting edge field of biologic drugs. This new class of medicines will help treat more Americans at lower costs. And the promise of protection for intellectual property and an FDA structure to approve biosimilars will result in increased investment in this industry, which already provides thousands of well-paying jobs in California and across the country.

I hope to work with the Secretary of Health and Human Services, the Commissioner of the FDA, and like-minded colleagues in Congress to ensure that these important research and manufacturing jobs stay right here in the United States.

In sum, this bill preserves and promotes the strength of the American health care system: job creation and growth and innovation: spending too much while caring for too few.

If we fail to pass this bill, we fail American families, and we fail the American economy. As a champion of both, I strongly support this bill.

Mr. ALEXANDER. Mr. Speaker, after months of meeting with constituents and business leaders, as well as hosting town halls and roundtable discussions, I can say that American public has clearly stated their opposition to this government takeover of health care.

H.R. 3962, the Affordable Health Care for America Act, states in section one that this legislation “builds on what works in today’s health care system, while repairing what’s broken.” I agree that improvements need to be made to drive down medical costs, but placing individuals under one bureaucratic umbrella does not build on what works or make any repairs. The bill includes the government-run public option, cuts Medicare and Medicare Advantage programs, and raises taxes on middle class families. In addition, the bill does not protect the interests of those nor does it adequately address defensive medicine. And, in the midst of states struggling with fiscal constraints, it will burden them with more unfunded mandates from the federal government.

In the President’s address to Congress on Sept. 9, President Obama said, “Nothing in our plan requires you to change what you have.” A study by the Lewin Group shows that two out of every three people would lose their current coverage, including up to 114 million people who would lose their jobs through their employer or other current coverage if a government-run plan “competes” with private companies. I don’t see the choice in this.

Medicare cuts total $162 billion. As a result, Medicare Advantage plans will drop out of the program, limiting seniors’ choices and causing many to lose their current health care coverage. Medicare Advantage has been successful in providing seniors with choice, selection and value. This is especially true for residents of rural America, where seniors have previously not had sufficient private alternative. Currently over 600,000 seniors are Medicare beneficiaries in Louisiana, while over 10,694 seniors in the 5th District are enrolled in the Medicare Advantage program.
The bill includes taxes on individuals who do not purchase government–forced health insurance. It also imposes new taxes on businesses who cannot afford to fund government–forced health coverage for their workers, therefore violating the bill’s new employer mandate and triggering an additional 8 percent payroll tax.

The bill also prohibits the reimbursement of over–the–counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), increases the penalties for non–qualified HSA withdrawals from 10 percent to 20 percent, and places a cap on FSA contributions. Because at least 8 million individuals hold insurance policies eligible for HSAs, and millions more participate in FSAs, all these individuals would not be able to keep the coverage they have without facing tax increases.

The grand total amount of tax increases included in this legislation equals approximately $729.5 billion over ten years. Imposing these new tax increases in the middle of a recession—with unemployment numbers we haven’t seen since 1983—will only harm the economy and kill jobs.

This bill intends to ensure that generic bio–logic companies will have to do some research before the FDA will approve them for use in the United States. This dramatically increases patient safety as generics come to market. Likewise, keeping research and trials in the country means more jobs at home. I hope this is included in discussions as the Affordable Care debate continues in the coming months.

The CBO has also said that this bill will increase seniors’ Medicare prescription drug premiums by 20 percent over the next decade. While the cost of living continues to rise during these tough economic times, I know that many cannot afford this increase. Medicare finances are rapidly deteriorating and we should be working on real solutions that ensure the long–term financial stability of Medicare.

Choice is not an option in this government takeover of our health care system. Anytime there is a mandate—whether it is forced health insurance or the public option—people are genuinely concerned for the well–being and options that the people of this great nation have. I do not believe H.R. 3962 best represents what the American people are asking for.

I agree that improvements need to be made to our system currently in place. However, a solution should be built upon the principle that when individuals—not the government, insurance companies, or employers—are given control and ownership, we will achieve full access to care. We then can see the entire system move in a more positive, patient–centered direction. America needs economic relief in the form of tax breaks for working families and small businesses, and fiscal discipline in Washington. Instead, our federal government keeps pushing policies that will impose harmful taxes and increase our national debt, saddling Americans who are already hurting with even more financial burdens. We must work to find real solutions that will help create jobs and lower health care costs.

Everyone can agree that affordability, accessiblity, portability, and quality should be the outcome of any overhaul of the health care delivery system. More specifically, it should be guaranteed that medical decisions are kept in the hands of patients and their doctors; the cost of insurance is lowered, and in turn the number of Americans who have insurance is increased. The American people deserve a plan that allows them to keep their health care coverage if they like it, and have the freedom to choose the plan that best meets their needs. As I will say again, I will not support any type of health reform plan that raises taxes, ration health care, eliminates employer–sponsored health benefits for working families, or allows government bureaucrats to make decisions that should be made by families and their doctors.

Mr. VISCLOSKY. Mr. Speaker, I am proud to support the Affordable Health Care for America Act, a bill that will significantly improve our healthcare system.

For too long, our healthcare system has allowed millions of Americans to go uninsured, tolerated egregious and abusive business practices by big insurance and pharmaceutical companies, and ignored skyrocketing costs. It has diminished our nation’s collective health and reduced our economic strength. The Affordable Health Care for America Act represents a significant effort to address the iniquities of our current healthcare system.

Specifically, the Affordable Health Care for America Act strengthens the healthcare market, with farmers and small businesses, and would require the Secretary of Health and Human Services to negotiate drug prices for Medicare.

America's economic engine, by establishing a Health Insurance Exchange where these businesses will benefit from large group rates and a greater choice of insurance options for their employees. Further, the measure would provide tax credits to eligible small businesses for assistance with the costs of providing health insurance to their employees.

Finally, the Affordable Health Care for America Act is not only fully paid for, but according to the non-partisan Congressional Budget Office it would reduce the deficit by $104 billion over the next ten years and would continue to reduce the deficit in the following decade.

Through these provisions and others I believe that the Affordable Health Care for America Act will accomplish my goals for healthcare reform, namely to give more security and stability to those who have health insurance, to provide affordable, quality options to those who do not have health insurance, and to lower the cost of healthcare for families, businesses, and society.

Although this bill may not be perfect, it will improve our healthcare system. It is the result of a lengthy, transparent process that has helped the bill evolve and improve at each stage of the way. I would certainly closely monitor the bill's progress.

Voting for comprehensive healthcare reform at last was a gratifying experience. I believe that a generation from now people will ask the question, what did I do to help improve the quality of life for so many families in our community, who will finally have access to quality affordable health coverage.

I am particularly pleased this legislation incorporates a provision that I, along with Majority Leader STENY HOYER, and others worked to include that will support the development of our medical school. The measure will allocate $100 million each year through fiscal year 2015 to the Department of Health and Human Services to help develop medical schools in federally-designated health professional shortage areas for construction, equipment, curriculum and faculty development. This is an exciting opportunity for our community.

The House passed the Affordable Health Care for America Act is one of the most significant legislative victories for the people of El Paso. Our community has one of the highest concentrations of America’s uninsured population, with over 230,000 residents without health coverage, one in three people. Texas has the highest rate of children and adults without health insurance in the entire nation. The status quo is unacceptable, and we can no longer afford to pass this growing problem to future generations.

While our community is paying a greater share of property taxes to pay for individuals without health coverage, insurance companies have continued to engage in practices that protect their bottom lines. For too long, insurers have been the gatekeepers to our health care, and are denied access to the medical care they need.

When people lack access to quality affordable preventative care, they end up in our

H12912

CONGRESSIONAL RECORD — HOUSE
November 7, 2009
I cannot understand how reducing the accountability of our healthcare practitioners would lower that number or improve the quality of healthcare in this country.

The facts are clear. Those states that restrict damage awards and limit access to courts for patients injured by negligence of doctors have seen limited or no reduction in healthcare costs. Instead, many have seen an increase in the cost of malpractice insurance. In fact, for every malpractice damage award, 3 to 7 people die due to medical errors.

While we all know that doctors' practice medicine with confidence and avoid needless tests, we should not limit access to justice where reckless action permanently alters the lives of patients and their families. Make no mistake, that's what the Republican substitute would do.

If we want to lower healthcare costs, let us instead cut down on medical error by encouraging adoption of best practices, standardizing safety procedures that are proven to reduce infection, and lowering malpractice premiums by creating more competition in the insurance industry. It is disingenuous for doctors who visited Washington this week. Many spoke about a fear of monopolies and in favor of increased competition. Let's make the insurance companies comply with antitrust laws and operate on the same competitive playing field as other American businesses.

One of the great guarantees the founders provided in our Constitution was the ability to address grievances in a court of law. Our courts remain a great equalizer that allows every American the opportunity to seek justice when wronged. This guarantee goes against that spirit and leaves grieving and injured families without access to justice. I ask my colleagues to join me in opposing this substitute.

Mr. CORRINE BROWN of Florida. Mr. Speaker, tonight, I'm thinking about my grandmother, and all the grandmothers out there—back in November of 2003 when the Republicans passed their Medicare Prescription Drug bill, they put a provision in there known as the donut hole. And that's why I voted against that bill, they put a provision in there known as the donut hole which has unfairly burdened the pocketbooks of seniors, decreasing out-of-pocket costs by $500 immediately, cutting copayments in half in the short term, and fully closing it over the next 10 years. H.R. 3962 also provides better access to prescription drugs by accepting Medicare and attacks waste, fraud, and abuse in Medicare ensuring more money goes to benefits and improving senior health and quality of life.

Too many people have the choices limited by insurance companies and financial decisions, rather than by patients and doctors. H.R. 3962 will expand individual choice and prevent insurers from denying benefits that doctors recommend. This bill will place caps on out-of-pocket health expenses, and remove the prescription drug "donut hole." It will provide greater access to health care for small businesses. Companies that offer their employees health insurance coverage will get a tax credit for two years to help them transition to, or continue, providing health benefits to their employees—paying up to 50 percent of their costs.

Mr. Speaker, as this bill moves to the Senate, I wish to caution the Senate. I am hopeful that we can make sure that H.R. 3962 does not unintentionally burden small businesses who employ seasonal workers. While tax incentives in the bill are designed to help small employers cover health care expenses, there are no incentives for seasonal farmers who work on the agricultural industry. Workers who are only employed for a short time by an employer should be able to get health insurance, but there must be provisions to ensure that this is affordable and not burden some seasonaries to the temporary employer. As we work through the process of passing a final bill to be sent to the President, I hope leadership will work with me to resolve this issue.
H.R. 3962 is fiscally responsible and will improve the health and health care of people across my district, North Carolina, and the country. I am pleased to be able to vote in favor of this historic legislation.

Ms. FOXX. Mr. Speaker, small business owners in this bill. A new tax-compliance paperwork burden on all small business owners.

This bill will kill jobs. It does nothing to lower the cost or increase choice in the marketplace for America’s small business. It will harm small business owners with costly employer mandates and punitive payroll taxes.

The Joint Committee on Taxation and the NFIAB agree that more of one-third of the $465.5 billion raised by this bill’s surtax will come from small business income.

Small business owners have shared their concerns about H.R. 3962 with me. One small business owner in Statesville N.C. summed it up:

"If this bill is passed the way it is written, my business will be unable to afford to comply with the mandates. My business has drastically cut expenses, delayed capital investments and decreased our work force to stay competitive. If H.R. 3962 is passed by Congress it will force us to close down our business and end the paychecks for the 56 employees who depend on our company to feed their families."

Mr. LUJAN. Mr. Speaker, as I came to the floor today I was reminded of a constituent, Aunt Adrian, who we lost to cancer this last year and who couldn’t afford insurance, she spent the last few months worrying about bills, rather than better. This story didn’t have to end this way.

We reached this point today because people have had enough.

People have been ignored and shunned, because they are sick;

People who have lost their homes and all they have because a health insurance company slammed a door on them and denied them coverage they thought they had. People who deserve to be treated fairly and with dignity.

We are here today not to frighten and scare the American people with things that are untrue.

But to act, to make a difference, to have the courage and will to put the people first.

And I now know that we do have the courage and the will to get this done, Aunt Adrian and the American people deserve no less.

Mr. RICHARDSON. Mr. Speaker, I rise today and urge adoption of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

I would like to thank Speaker PELOSI, House Majority Leader HOYER, Congressman DINGELL, Congresswoman RANGEL, and Congresswoman WAXMAN for their skill and leadership in bringing this historic bill to the floor. I would also like to thank my colleagues who have worked so hard to bring about a workable solution to one of the most critical challenges in the history of our nation.

President Theodore Roosevelt proposed national health insurance in 1908 because he could not stand by and watch American families go bankrupt when their children fell ill. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for older citizens. Thirty years later, Congress passed the State Children’s Health Insurance Plan which expanded affordable coverage to millions of poor children.

Today, this seventh day of November in the year 2009, we have the chance to make a new chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won’t bankrupt their families. Today, we keep faith with those who came before us and those who will come after us. Today, we will pass the Affordable Health Care for Americans Act of 2009 and change America for the better.

The health care system we have now is not working for middle and working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured. There are 54 million Americans who are uninsured who need us to reform this broken system. 1 in 5 Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, House Republicans have offered a bill that they claim solves the broken health care system, but the reality is quite different from what their rhetoric makes it out to be. The health care substitute leaves affordable health insurance out of reach for millions of Americans. It will allow discrimination based on gender, age, and pre-existing conditions to prevail in the insurance industry. It will do nothing to protect consumers. It is not the answer.

Mr. Speaker, the Affordable Health Care for Americans Act is a better bill. It is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose week-by-week for their livelihood. This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies. This bill provides American families with greater choice. It creates a high-quality, robust, public health insurance option for families who choose from. Finally, this bill lowers costs for American families. It eliminates co-pays and deductibles for preventive care while putting an annual cap on out-of-pocket expenses for American families. In short, Mr. Speaker, our proposal addresses the very problems faced by real American families today. The Republican bill is fantasy. It is not grounded in reality. Now, we need to stop playing politics and focus on actually improving people’s lives. H.R. 3962 will reform the health care system so that it provides quality, affordable care and that obstruction be taken away. This bill eliminates discrimination based on gender and pre-existing condition. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

As FDR once said, the test of our progress is not whether we add more to the abundance of those who have much, it is whether we provide enough for those who have little. It is time for us to move forward. It is time for us to take this great nation in a new direction. It is time for us to look out for all Americans in their time of sickness and need. The hour is late, and the need is great. I urge my colleagues to vote ‘aye’ on H.R. 3962.

Mr. SHULER. Mr. Speaker, as you know I am opposed to the bill we are considering today for many reasons that I have articulated previously. I am pleased, however, that the bill strikes the appropriate balance on the issue of the right to try. The compromise language will provide lower cost options to consumers and my constituents without destroying a healthy and functioning biotech industry in this country. The Barton-Eshoo biosimilar amendment in the Energy and Commerce Committee was one of the few issues that was addressed on a truly bi-partisan basis and ought to serve as model on how things should get done in Congress.

I believe it is critical that the creation of a pathway for new products does not destroy the ability or the incentives of innovator companies to develop breakthrough technologies. We have a moral obligation to provide a safe and effective pathway of bringing competition that will benefit patients. I wish we could consider this as a stand-alone bill because it would pass with the kind of overwhelming bipartisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure that it is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country and in my home state of North Carolina. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries that don’t have the same safety and efficacy standards that we have in the United States. When this week’s devastating news of unemployment has reached 10.2 percent it is critical that we preserve jobs in America. While the innovators have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovator products. In other words, whether these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should be required to occur in this country to ensure that it is done properly and safely.

Mr. BOOZMAN. Mr. Speaker, the Pelosi Health Care Bill is a bad bill disguised as health care reform. I have heard my constituents and the American people and they say they don’t want this government takeover. They want the right to make their own health care choices. I agree that we need health care reform because the costs are too high. There
is nothing more frustrating as a medical professional than when my patients can’t afford the prescriptions I write for them. The Majority plan will put Washington between me and my patients and this is unacceptable.

We all deserve access to quality and affordable health care. Unfortunately, this plan doesn’t guarantee that we will accomplish this. This government takeover will increase taxes, take away health care choices Americans deserve to make and create more bureaucratic red tape. We don’t want reforms that come with higher costs while the quality and access to health care continue to deteriorate.

The cost is a staggering $1.2 trillion and to think that won’t impact our national deficit and state budgets is unrealistic. The increased price for greatly expanding Medicaid will be an unfunded mandate to Arkansas taxpayers that at the bare minimum will cost $205 million and could be as high as $596 million. This is an unfunded mandate that we cannot force Arkansans to pay. Health reform should not end up costing hardworking Americans. Our citizens deserve better.

Mr. Speaker, today I will vote in strong opposition to H.R. 3962, the “Affordable Health Care for America Act.”

This government takeover of health care is filled with tax increases, job killing mandates, Medicare cuts, bureaucratic additions, and entitlement expansions. This bill will not only hurt health care premiums and a growth in long-term health care costs.

Despite this bill’s many faults, I support the bill’s language establishing a market for biosimilars which balances the desire to provide cheaper biologics with the need to continue incentivizing investment in research and development. The bipartisan language approved by the House Energy and Commerce Committee earlier this year would create an FDA approval process that allows for the continued development of biosimilar products.

This language appropriately protects intellectual property rights by encouraging the creation of new technologies and helps protect patients from possibly dangerous, insufficiently tested biosimilars. Because biologics are more complex and harder to replicate than their chemical counterparts, the need to develop and confirm the safety and efficacy of these new products is of the utmost importance that we only support a process that provides for a safe biosimilar market.

It is critical at this time of 10.2 percent nationwide unemployment that the federal government allow job creating industries, like biotechnology, to continue to invest and create jobs. It is unfortunate that the Majority wrapped up a good biosimilar bill in a bad health care bill, but I hope that we have the opportunity to support the Eshoo-Inslee-Barton biosimilar provisions in a separate legislative vote.

Mr. MCCARTHY of California. Mr. Speaker, I rise today to express my strong opposition to H.R. 3962. Specifically, I am very concerned about how the House Democratic Leadership’s govern ment solution to the health care legislation will affect the biotech industry, which will need to continue to research and develop new treatments.

Californians know very well how the burden of heavy taxes and regulations can harm small businesses and innovation, as our state economy continues to lag and continues to have an unemployment rate much higher than the national average. On top of state taxes and regulatory burdens, H.R. 3962 would only add on to the devastating burdens facing our biotech industry, through its $20 billion excise tax on medical devices and by establishing a pathway for follow-on biologics that could harm innovation and American jobs.

As one of the biotech leaders in our country, California is home to 134 biotechnological companies and has created more than 271,000 jobs. The proposed excise tax, whose purpose seems to be solely to raise revenue, is a job killer and would stifle innovation. It will ultimately result in making it more difficult for millions of Americans to have access to life-saving medical products that they need for their health and well-being.

Further, H.R. 3962 would establish a new pathway for follow-on biologics that could slow advances to new life-saving therapies, and ultimately reduce the number of American jobs. The bill does not expressly require clinical trials for follow-on biologics to be completed in the United States, which could allow for these studies to be conducted overseas. Over the past decades, many innovator biologics have demonstrated to be safe, reliable and life-changing—products of strong clinical trials and research done by dedicated researchers here in America. As unemployment has now crossed 10 percent nationally, and is over 12 percent in California, I hope that we could continue to foster the creation of jobs and research.

These are some of the many concerns I have with H.R. 3962, which is why I instead support the Republican health care alternative. The alternative excludes the unnecessary and burdensome excise tax in H.R. 3962, and also includes a responsible pathway for follow-on biologics by including provisions from the Pathways for Biosimilars Act, which I am a proud cosponsor of. By passing the Republican alternative, we can ensure that the American biotech industry can continue to lead the world in innovative therapies and that the necessary research and clinical testing in the field can continue to be done domestically so we can continue to create good-paying American jobs.

Californians, and all Americans, need Washington to pass strong, patient-centered health care solutions. But we need solutions that strike a balance in reducing health care costs, strengthening health care access, and allowing health innovators, like our biotech industry, to continue to research and improve therapies for patients. That is why I support the Republican health care alternative—it addresses the needs of patients and ensures that we keep good-paying jobs in America.

Mr. BONNER. Mr. Speaker, I rise today to state my objection—in the strongest way I know how—to Speaker PELOSI’s health care bill.

This bill represents everything I have fought against during my years in public service. It raises taxes by hundreds of billions of dollars, it hides deficit spending with dubious accounting gimmicks, and it will vastly expand the federal government’s scope and size in every aspect of our daily lives and take even greater control over one sixth of our nation’s economy.

Among other things, this bill piles crushing mandates on small businesses, it wrings hundreds of billions of dollars out of our doctors, hospitals, and other providers. It decimates the popular Medicare Advantage program, which millions of seniors depend on. Moreover, it will be the mother of all unfunded mandates on state budgets which—like my home state of Alabama—are already stretched thin because unlike the federal government, most states actually balance their budgets.

Mr. Speaker, over the past several months I have met with numerous Alabamans who have called, written, and e-mailed my office. In August, my staff and I held 19 town meetings throughout Alabama’s First District where more than 5,000 people came out to voice their opposition to this massive takeover of our health care system.

California and colleagues, the vast majority of the people I work for—and have heard from—are unambiguous—they do not want this bill.

In fact, most Alabamians—and, I believe, most Americans—want to preserve what’s best about our health care while lowering costs and improving access. That’s why I will not only be opposing H.R. 3962, but I am proud to support the Republican substitute. My Republican colleagues and I believe this bill would lower costs in both the short term and the long term, honor our pledge for fiscal responsibility while broadening access to quality health care through lower costs and more competition.

Mr. Speaker, I only have one vote but I will cast that vote against this legislation that The Wall Street Journal correctly dubbed, “the worst bill ever,” and I humbly urge my colleagues to do the same.

Ms. HIRONO. Mr. Speaker, the U.S. Congress has been grappling with how to provide all our citizens with access to affordable, quality health care since the time of President Harry Truman. H.R. 3962 represents a critical milestone in the effort to reform our health care system.

For those who have it, health insurance is not something you can take for granted. Every day 14,000 Americans lose their health insurance coverage for an unprecedented number of reasons like asthma, pregnancy, arthritis, or diabetes. Millions more have no health insurance at all, including 54,000 people who live in Hawai’i’s Second Congressional District.

In his health care speech before Congress and the nation, President Obama appealed to the best part of us—to act unselfishly, and to put ourselves in the shoes of others. He asked us to imagine what it must be like for those who don’t have insurance—to live in a State of helplessness should illness strike you or the ones you love.

H.R. 3962 is a bill that will provide for comprehensive health care reform that will protect consumers, hold insurance companies accountable, rein in health care costs, reduce the deficit, and cover 36 million uninsured Americans. In supporting this bill, I want to highlight three key points. First, for Hawaii the bill includes the Hirono Amendment that provides an exemption for Hawaii’s Prepaid Health Care Act of 1974, which is our nation’s first and only employer mandate law of its kind. Second, the bill will provide health insurance for a high number of Americans while still reducing our deficit. And third, the bill strengthens and improves the Medicare program for our seniors.
First, there is a mistaken perception that everything and everyone in Hawaii is exempted under H.R. 3962. That is not so. The Hirono Amendment only exempts Hawaii’s Prepaid Health Care Act (PHCA) and those who come under it (certain full-time employees and their employers). It does not apply to the employees, seniors on Medicare, those without health insurance, government employees, or those covered by collective bargaining agreements.

Therefore, H.R. 3962 would apply to them. I know it is easier to talk in terms of the State of Hawaii being exempt from the bill, but that is wrong. The distinction between PHCA being exempt and the whole State being exempt is a critical distinction to make.

PHCA—those with incomes to contribute at least 50 percent of the premium cost for single health care coverage, and the employee must contribute the balance, provided the employee’s share does not exceed 1.5 percent of his or her wages. Because of rising health care costs, the state of Hawaii has to pay for 84 percent of the premium cost because of the second part of Hawaii’s law limiting employees’ share. Hawaii employers may cover the full cost of the health insurance premium and many do cover 100 percent of the cost of single coverage. H.R. 3962 would require employers to cover 72.5 percent of premium costs for single health care coverage.

Hawaii consistently ranks among the highest nationally in terms of insurance coverage and lowest in regard to the number of uninsured. This is largely due to PHCA. Private and public health insurance cover an estimated 92 percent of our population of 1.3 million people. Of those with private insurance, 93 percent are covered through employment-based plans.

Lawrence Ball, an economist at the University of Hawaii, estimates that per capita health expenditures in Hawaii are seven percent lower than the national average. Dr. Boyd believes that wider health insurance coverage and support for preventive health care lead to this outcome. The Hirono Amendment would provide maximum flexibility for Hawaii once a federal health care reform bill becomes law. Hawaii will be able to decide for itself to retain PHCA or come completely under the new federal law.

Second, H.R. 3962 will ensure that 96 percent of Americans will have health insurance coverage. The non-partisan Congressional Budget Office (CBO) estimates that the cost of enacting H.R. 3962 will be $894 billion, consistent with the $900 billion limit established by President Obama. The bill is fully paid for.

About half of the cost of H.R. 3962 is paid for by targeting waste, fraud, and inefficiency in the federal Medicaid and Medicare programs. The other roughly half of the cost of the bill is paid for through a surcharge on the wealthiest Americans—those with incomes above $1 million for couples and $500,000 for singles; therefore, 99.7 percent of Americans will not be touched by this surtax.

While H.R. 3962 will be paid for, CBO also estimates that it will reduce the deficit by over $100 billion in the first 10 years, and continues to reduce the deficit in subsequent years. Leading economists from educational institutions across our nation have concurred with CBO’s findings and support the idea that health care reform promotes our country’s economic health.

Finally, I want to address the importance of health care reform to seniors. Some of the most damaging misinformation that has circulated over the past several months on health care reform is the use of scare tactics targeted at seniors. The cynical irony is that the misinformation targeting seniors is largely perpetuated by the same people who fought the establishment of Medicare and wanted to privatize Social Security.

The truth is that H.R. 3962 will lower prescription drug costs for people in the doughnut hole; give the Secretary of Health and Human Services the authority to negotiate lower drug prices on behalf of Medicare beneficiaries; and extend the solvency of the Medicare Trust fund by five years.

Closing the doughnut hole is an especially critical issue for Hawaii, as we have the nation’s largest percentage—56 percent compared with 26 percent—of Medicare beneficiaries who fall into this gap of prescription drug coverage. In its first year, H.R. 3962 will reduce the doughnut hole by $500 per beneficiary, provide a 50 percent discount on brand-name prescription drugs, and phase out the doughnut hole by 2019.

It is remarkable that just the past two days, over 300 groups representing Americans from all walks of life—doctors, farmers, seniors, consumers, cancer and diabetes patients—have rejected the unsustainable status quo and have endorsed H.R. 3962. In its endorsement of the bill, Consumers Union, publisher of the independent, non-partisan Consumer Reports—called the health care status quo a “consumer crisis with its crippling costs, its unreliability, and lack of access,” and strongly endorsed the House of Representatives health care bill because it will create “a more secure, affordable health care system.” Other groups endorsing the House bill include the: American Medical Association, American Nurses Association, AARP, AFL-CIO, AFSCME, Americans for Democratic Action, American Cancer Society, American Diabetes Association, Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, National Association of Community Health Centers, National Education Association, Campaign for Tobacco-Free Kids, and from my district, Lana’i Community Health Center.

Mr. THORNBERRY. Mr Speaker, I rise today to express my opposition to both the rule and to the massive government takeover of health care that is before us today. There are a large number of issues that I could raise, but right now I would like to focus on one of the most blatant examples of disregard for the will of the American people found within this bill. The bill includes abortions paid for by federal dollars.

For more than 30 years, the United States federal government has not been in the business of providing funding for abortion. Since 1976 the Hyde amendment has struck a delicate, but respectful balance between those who support abortion and those who do not. While it does not make abortion illegal, it protects those who oppose abortion from being forced to support it with their taxpayer dollars. This is a fair compromise that should be included in the H.R. 3962.

Public opinion is clear on this issue. A number of polls have been conducted in the last couple of months showing Americans do not support federal funding of abortion. A Rasmussen Reports poll from September found that only 13 percent of Americans support abortion coverage by government-backed health insurance. A Public Option Strategies poll from September found that only 8 percent of Americans would be more likely to support a health care bill if it included federal funding for abortions. A whopping two-thirds of Americans oppose using federal dollars to pay for abortions, according to the September International Communications Research poll. This is every other aspect of this health care bill—the American people do not want it, but Democrat leadership is attempting to ram it down our throats anyway.

This is why I support the Stupak-Pitts amendment. Their amendment would extend the same restrictions found in the Hyde amendment to cover this bill as well. It does not outlaw or prohibit abortion, or restrict those who wish to have an abortion from seeking one. But it does prevent federal dollars from being used to pay for those abortions.

I am pleased that we will be allowed to debate the Stupak-Pitts amendment, even without assurance that it should pass, the House would retain the language in conference, and
I hope that my colleagues vote in favor of the amendment. The Republican bill clearly states that abortions will not be paid for with taxpayer dollars. I urge my colleagues to vote for the Republican bill and against H.R. 3962.

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Affordable Health Care for All Americans Act. In my 21 year career, this is by far one of the most important votes I will take. I have spent the past ten months meeting with the people of Bronx, Rockland and Westchester Counties and have had heart-breaking stories in which me about the inadequacies of healthcare.

On this historic day, our Congress honors our country, honors our citizens, and honors our moral imperative to provide all Americans with comprehensive, affordable access to quality health care.

This is the reason so many of us get up day after day after day. It is the reason why so many of us sought public office, and it is the reason why our constituents sent us to Congress—to right the wrongs of our broken healthcare system and steer our country back in the right direction.

Never again will families worry late into the night over whether their pre-existing medical conditions will prevent the loved ones from getting access to health care coverage they so desperately need.

Never again will insurance companies be allowed to drop coverage for those who have paid their premiums diligently, only to lose it when they get sick and need it most.

Never again will families have to worry that if they lose their jobs, they will also lose their healthcare coverage.

The underlying bill provides comprehensive reform to our nation’s healthcare system and puts our nation back on the road to fiscal responsibility by reducing the deficit by $30 billion in the first 10 years.

Regardless of who you are, or where you live, this bill provides significant benefits to all citizens.

If you have health insurance, you can keep your doctor and your health plan. You like it, you keep it. It’s that simple.

But for those that don’t have health insurance, I worked to protect the ability of eight states, 53 percent of Americans desperately want to purchase health insurance and can’t. They’ve been priced out of the system. They have been priced out of basic desire to keep them and their families healthy. 53 percent of Americans postpone care or medication because of cost.

60 percent of bankruptcies were related to medical debt. It’s unfair, unsustainable and un-American to allow this failed health care system to continue.

Insurance companies have a chokehold on the market and we are breaking through that today. If you don’t have health insurance, or lose your health insurance, the new health insurance exchange will provide a one stop comparison shopping market place for you of private health plans or a new public health insurance option.

While in my heart of hearts I believe a single payer system would be the best reform of our nation’s health care, I have worked tirelessly over the last year to enact a strong public option. The public option included in the bill will undoubtedly inject competition into the market for better prices and coverage of quality health care.

No longer will women be considered second class citizens when it comes to healthcare coverage. H.R. 3962 supports women’s health care by ending the designation of pregnancy, domestic violence and caesarean sections as pre-existing conditions, and eliminating out-of-pocket expenses for preventive services including mammograms, baby and well-child care visits. It also prohibits plans from charging women more for health coverage than men, and guarantees coverage for maternity care.

H.R. 3962 invests in Medicare. Our seniors will see improved benefits, free preventive care, better primary care and lower drug costs. The donut hole, in which seniors pay monthly premiums for drug coverage without a drug benefit, will finally be closed. I have been fighting for this since the day we enacted the Medicare Prescription drug benefit.

Young adults will have more access to affordable healthcare than ever before. Our bill allows adults to stay on their parents’ healthcare plans until their 27th birthday. This measure alone will cover one out of three uninsured young adults.

Additionally, small business owners will be granted access to affordable large group rates in the new insurance exchange and tax credits to help businesses insure employees across the 17th district and our nation. I met with the Rockland Small Business Association this summer and fought to make health insurance reform workable for small businesses. 98.8 percent of small business owners will pay no surcharge and 86 percent of America’s businesses are exempt from the shared responsibility requirements. In fact, businesses with payrolls of $500,000 or below are completely exempt from provisions in H.R. 3962.

Throughout this year, and in my role as the Senior New Yorker on the Energy & Commerce health subcommittee, I have worked hand and hand with Chairmen WAXMAN, RANGEL, MILLER, Majority Leader HOYER and Speaker PELOSI to improve the underlying bill for New York State and people nationwide.

Here are just a few of the provisions I was successful in getting into the underlying bill.

I am proud to have reformed the Medicaid program to serve people with HIV. Under current Medicaid rules, low-income people with HIV must wait until they are disabled by AIDS before they can get covered by Medicaid. In the House bill, states could cover all people with HIV infection under state disability income and resource levels until January 1, 2013, when the new health insurance exchange is operational, at an enhanced federal match.

I worked to protect the ability of eight states, including New York, to maintain a Medicaid Early Day Health care programs in Medicaid. These community-based long term care programs provide comprehensive health care services in day settings.

Beneficiaries are given nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine, daily basis.

Since my time in the New York State Assembly when I was the Chair of the Assembly Committee on Alcohol and Drug Abuse, I have been championing for mental health and substance abuse services. I worked to strengthen our capacity to serve people affected by these disorders through Federally Qualified Behavioral Health Centers. My provision will establish national standards of care for persons with serious mental illness and addiction disorders. Furthermore, new reporting and accountability standards for mental health care will better integrate its providers and services within the larger healthcare.

Many people have a family member, or are friends with someone who has autism. I worked with Rep. DOYLE, the Co-Chairman of the Congressional Caucus on Autism on several provisions dear to me. We ensured that diagnosis, treat and support patients with Autism Spectrum Disorders (ASD). These professionals require the most up-to-date practices to best care for those with autism and their families. And so we included a provision for the training for professionals working with children and adults with autism.

I advocated to improve the healthcare for maternity and newborn care in the Medicaid program. H.R. 3962 will extend important child health quality improvement provisions to traditionally healthy children aged 0-1 and newborns and other covered adults younger than age 65. As a result of my provision, the Secretary of Health & Human Services will collect data and make recommendations on improving care for these key populations.

Finally, I was tireless in my advocacy for the Disproportionate Share Hospital (DSH) program, which assists with the cost of caring for uninsured and underinsured people at hospitals. These payments ensure that hospitals are not in financial distress from serving low-income people.

We stand here as proud Americans determined and ready to transform a broken health care system into a model of care worldwide. The cost of inaction is too great. Today, we answer the call of history, and vote for health insurance reform for America. Our nation’s future depends on it.

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the “freedom” to be uninsured. Senators Against Poverty do not view themselves as enjoying some “freedom”; they want insurance.

The Republican substitute responds to the comprehensive Affordable Health Care for America act with a bill that fails to reduce cost, fails to cover uninsured Americans, and it may study—but it does not help—those with pre-existing conditions. It does, however, attack in need victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs. Yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of medical malpractice. For the victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts the costs of medical malpractice from the doctor to the victims’ own private insurance, and in many cases causes the injured victims to lose the right to sue before they even know they’ve been injured. I’d like to share some specific examples of the egregious provisions included in the Republican substitute.

November 7, 2009

CONGRESSIONAL RECORD — HOUSE

H12917
Under the Republican substitute, a young child whose life is forever devastated by medical malpractice can lose all right to sue on his or her eighth birthday—long before he or she reaches legal age to make his or her own decision.

Under the Republican substitute, when two or more wrongdoers act together, and one of them is able to flee or put their assets out of reach, the innocent victim is left short, while the other wrongdoer is shielded from full responsibility. They call this the “fair share rule.”

Under Republican substitute, it is more difficult for a medical malpractice victim to get a lawyer’s help to fight against the insurance companies, because the bill permits a court to reduce the fee paid to the victim’s lawyer—after the case has been fought and won. This provision penalizes victims with winning cases. One would think the purpose of this provision is to save the insurance carrier money and thereby reduce malpractice premiums; however, insurance carriers are not responsible for the victim’s lawyer’s fee. Insurance carriers are responsible for the defendant’s lawyer’s fee, so penalizing them is a way for the money to become off the books. The substitute does not allow that. This makes no sense. Under current practice, the victim’s lawyers already don’t get paid if the victim loses. If they might not get paid even if the victim wins.

Under the Republican substitute, if the victim has health insurance that helps pay for the victim’s care while the victim is waiting for the wrongdoer to be held accountable, the wrongdoer can escape legal accountability for that part of the cost entirely. The wrongdoer gets to shift the cost onto the victim’s own health insurance. That’s the Republican approach to health insurance reform—saddling the victim’s insurer with the cost of someone else’s negligence, while letting the wrongdoer off the hook.

Under the Republican substitute, the only time punitive damages would ever be available is when the wrongdoer has maliciously injured the victim that is, when the wrongdoer has committed a violent felony. And even then—even in cases of the most heinous violence imaginable—the Republican substitute caps punitive damages.

The Republican substitute is empty of any meaningful health insurance reform, and it is utterly callous to malpractice victims. None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now. The substitute should be defeated.

In contrast, the majority’s Affordable Health Care for America Act reduces the number of uninsured, increases accessibility of health care, controls skyrocketing costs, and addresses the denial of coverage based on pre-existing conditions. This legislation will put us on a new path where health care will be affordable for everyone for a lifetime for a luxury for some, and I am proud to support this historic health insurance reform legislation.

Ms. NORTON. Mr. Speaker, I support the Affordable Health Care for America Act both because of the extraordinary step forward it brings for the nation and my district, the District of Columbia. First, I took steps to assure that the Affordable Health Care for America Act we expect to pass tonight would treat the District equally with the 50 states (although it does not do so for the territories). Consequently, the bill will provide coverage for 14,000 uninsured D.C. residents and affordable credits to help up to 134,000 D.C. families pay for coverage; will improve employer-based coverage for 363,000 District residents; will provide Medicare for 75,000 D.C. seniors, including closing the prescription drug donut hole for 3,300 seniors, as well as providing free preventative care and wellness check-ups for all seniors; will allow 22,200 D.C. small businesses to obtain affordable health care coverage; and will save about 400 District families from bankruptcy resulting from unaffordable health costs. The bill will also reduce the cost of uncompensated care by $126 million for the District’s besieged hospitals and health care providers.

I am proud of the remarkable advances made by our bill, even though it does not meet all that I pressed to achieve. The Congress, of course, is not known for perfect bills, but the extraordinary diversity of our Democratic Caucus—from right to left—has assured that this bill represents a cross-section of the American public—urban, suburban, and rural. The incredible diversity of the Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could go to the floor only with a bill that sensibly puts all of America together into one reconciling bill. That is why we have produced a bill that satisfies hawks, more wary of increasing deficits than of most other issues as well as single-payer advocates, who believe that only Medicare for all can sufficiently reduce costs while keeping health care to the middle class and the uninsured. Thus, there can be no doubt that the Affordable Health Care for America Act is a balanced bill.

The bill’s greatest achievements are that it will reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; will end discrimination by insurers who dropped or refused to renew or sell coverage because of health status; and will ensure that coverage is affordable by providing subsidies for employer-based health care or through the insurance exchange of private insurers as well as a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

I particularly support this bill because it will take off the burden that the District of Columbia heroically took on, beginning with the Williams administration, to offer health care to the uninsured, without any assistance from the federal government, rather than subject them, without them, to the facts of life. And every American emergency room care, the most expensive available. The District’s Health Care Alliance, which provides insurance to more than 50,000 residents lacking health insurance, who do not qualify for Medicaid or Medicare, is collapsing under the weight of increasing requests from individuals without costs while the city had to cut its Health Care Alliance budget this year to 46,000 individuals, although a year ago 48,000 individuals had registered and 55,000 were expected to register in the 2010 fiscal year.

At my “Fact Check Town Hall Meeting on Health Care Reform,” which observers said was notable for its civility and the diversity of residents attending, it was apparent that District residents strongly support the approach taken by today’s bill. By September, my office had received 2,000 contacts on health care reform, almost all supporting the reform efforts underway in the House, with only nine residents expressing opposition to any reform. Also, 276 District residents had written in opposition to parts of the proposed bill, and 220 of them supported the public plan who opposed the public plan, appeared to believe that such a plan would affect their employer-based plans, which this bill ensures cannot happen.

I believe that this bill is strong and compelling enough to offer stiff resistance to those who have been unwilling or unable to consider special interests and who may now believe their best hope is in the other body. Tonight, this bill provides the best hope for the health care of our nation’s long-suffering people.

Mr. PAULSEN. Mr. Speaker, like many of my colleagues on both sides of the aisle, I believe that status quo on our nation’s health care is unacceptable. We need real reform in this country that will lower costs and keep health care decisions in the hands of patients and their doctors.

This bill would establish a new government run bureaucracy and a public-plan that will drastically expand the role of government into personal health care and control the cost of health care for all. It would impose $729.5 billion in higher taxes. $135 billion in taxes will be levied on business. $20 billion in taxes will be levied on medical device manufacturers. Using President Obama’s economic measuring stick, as many as 5.5 million jobs could be lost from the taxes in this bill.

We all heard and over and over again that, “those of you who like your health care plan can keep it.” What is not mentioned is that every plan will need to meet government requirements for a government seal of approval. This plan will cut $500 billion in Medicare benefits, including over $170 billion in cuts to Medicare Advantage, a plan that is used by more than 19,000 seniors in my district. These seniors will no longer get the same care and coverage that they need.

Mr. Speaker, in the bill before us there is no provision in this bill to allow small businesses to pool together, no protection for those who want to keep the coverage they have, and no medical liability reform.

The health care plan I support lowers health care premiums for all Americans, guarantees affordable coverage for patients with pre-existing conditions, protects seniors, Medicare benefits, includes no tax increases, empowers the doctor-patient relationship, and protects the budget deficit.

I also want to point out that I offered five amendments to the healthcare bill, but none were made in order. The first amendment would have removed the enormous medical debt tax from the bill and replaced it with an obliging stimulus fund. It was my sense to me that this bill taxes innovation and our job creators and takes away funding for life saving technology.
November 7, 2009

CONGRESSIONAL RECORD — HOUSE

H12919

I had an amendment that would have required a study of the harmful effects the innovation tax would have on the medical technology industry. Americans should know the implications of the negative effects on life saving technologies in this nearly 2,000 page bill. I offered an amendment to remove the seasonality and temporary workers from the employer mandate. This amendment would have helped to lessen the heavy burden this legislation imposes on small businesses.

In addition, I offered an amendment that would have improved and expanded health savings accounts. This would have helped make health care more affordable for the millions of people covered by high deductible health plans.

Finally, I offered an amendment to clarify that nothing in this bill would have infringed on the health care that was promised to our nation’s veterans. Unfortunately, this health care bill makes massive changes and our nation’s veterans are owed the assurance that they will have the means to care.

Mr. Speaker, I would like to close by saying that I oppose this bill because it puts the government in between the decisions of a patient and their doctor. This is simply unacceptable. Patients should have the right to make their own choices regarding the medical care they need without government interference. Whether it is taking care of your children, parents or grandparents, there is no issue that is more personal to a family than health care. No special interest group, Member of Congress or federal bureaucrat should stand between a patient and their doctor.

Americans continue to lose jobs and faith in their American government each day. This bill is not only the wrong direction for our economy but also the wrong direction for America.

Mr. BISHOP of Georgia. Madam Speaker, after months of studying the various proposals, listening to feedback from my constituents on both sides of the issue in town hall meetings, informal discussions, letters, e-mails and faxes, and after prayerful reflection, I concluded that I must support the health care legislation to provide tax credits to nearly 14,000 small businesses in the Second Congressional District who offer their employees coverage and exempts 86 percent of small businesses (those with payrolls of less than $500,000) from having to provide coverage, and continues the business deduction for those who do.

Finally, the House health care bill prohibits the use of federal funds for abortions. It also requires verification of citizenship or lawful presence for undocumented immigrants to receive coverage.

I look forward to further improvements as the bill is considered by the Senate and the Conference Committee, where differences between the House and Senate bills will be resolved. But this evening’s vote is a significant step towards affordable, quality health care for all.

Mr. KENNEDY. Today is truly a historic day for all Americans, and as an elected official of this great democracy, it is an extremely proud day for me. It is an occasion to celebrate and thank all those who fought to protect our nation’s democratic process. It is also an occasion to recognize and remember all those Americans who have suffered waiting for this day to arrive. We have worked together to achieve this goal of quality, affordable health care for all the people. I express my sincere gratitude, and I rejoice with you today that a new chapter in our history has begun.

The Affordable Health Care for America Act creates basic protections for all Americans seeking access to healthcare. No longer will insurers be able to drop you from your insurance when you get sick, nor can they deny you coverage for a pre-existing condition. A public option will offer a choice for consumers and provide real competition to keep private insurers honest. Affordability credits will help individuals pay the cost of purchasing health insurance. Additionally, these reforms are fully paid for and will actually lower the deficit over the next 10 years.

I am proud that the final version of this legislation includes numerous provisions I have long advocated for and worked with my colleagues to achieve. While the initial draft of the Affordable Health Care for America Act grossly closed the donut hole for Medicare prescription drug coverage last August, I am pleased to have worked with the Speaker to successfully reduce the timeline in which this critical reform will take place. The donut hole will now begin to close immediately and will close completely by 2019, providing much needed assurance and relief to seniors starting next year.

Likewise, I am also pleased that the Affordable Health Care for America Act eliminates lifetime caps, provisions of many health insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. I authored a letter, signed by 23 of my colleagues, urging this lifesaving provision to become effective immediately. I am pleased that the elimination of lifetime caps on insurance has been made effective in 2010, so that none of the 25 million individuals with lifetime caps each year will ever wait for the provisions to take place.

A key aspect of this legislation that is of particular importance to me is the extension of the mental health parity protections established in law last year. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Not only are these protections extended to all plans in the Health Insurance Exchange, but mental health and substance use benefits are a part of the essential benefits package created by this legislation. For 67 percent of adults and 80 percent of children needing mental health care that do not receive it, this victory cannot be understated. I commend my colleagues and my fellow citizens for their leadership in recognizing that the health of the mind truly cannot be separated from the health of the body. Today marks a new day and a giant leap forward towards our transition from a “sick care” system to one which is preventive, collaborative, and patient-centered.

Along these lines, I have also worked closely with my colleagues to ensure that mental health and substance use screening tools, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), were included in this legislation. Severe mental illnesses are estimated to cost the U.S. hundreds of billions annually in lost wages. Screening for mental health and substance use has proven to be a significant cost saver for our health care system. The Affordable Health Care for America Act establishes a program to provide grants to states to improve critical services.

I will continue to work with my colleagues to ensure that our health care professionals have the tools that are needed to recognize mental health and substance use in their patients. This means ensuring that mental health and substance use education be required of all health care professionals and integrated into the medical curricula, continuing medical education, and licensing examinations. It also includes addressing the drastic shortages of child and adolescent mental health professionals by providing loan forgiveness and matching grants to providers to develop, expand, and improve training programs for professionals who serve children and adolescents. Language to this effect is included in Medicare part D prescription drug coverage for seniors. It will outlaw denial of coverage for people with pre-existing conditions, limit premium discrimination based on gender and age, and prevent insurance companies from dropping coverage when people develop serious illnesses and need it the most.

In addition, this legislation includes funding for community health centers and other primary care providers, doubling the number of patients seen over five years. It will extend coverage for young people to stay on their parents’ insurance plans up to their 27th birthday. It will extend health insurance coverage for displaced workers. Furthermore, it will hinder price-gouging by requiring that insurance companies disclose rate increases.

By 2013, when the mandate for coverage and the Exchange are in place, additional provisions will take effect including no more copays for routine checkups and preventive care, yearly caps on individuals’ out-of-pocket expenses and no lifetime caps on what insurance companies will cover.

The addition to these benefits for Southwest Georgia, that will reduce the federal budget deficit by $104 billion over the next decade. It will allow states to form compacts that will enable consumers to buy policies from insurers across state lines.

With regards to small businesses, the health care legislation will provide tax credits to nearly 14,000 small businesses in the Second Congressional District who offer their employees coverage and exempts 86 percent of small businesses (those with payrolls of less than $500,000) from having to provide coverage, and continues the business deduction for those who do.

Finally, the House health care bill prohibits the use of federal funds for abortions. It also requires verification of citizenship or lawful presence for undocumented immigrants to receive coverage.

I look forward to further improvements as the bill is considered by the Senate and the Conference Committee, where differences between the House and Senate bills will be resolved. But this evening’s vote is a significant step towards affordable, quality health care for all.

Mr. KENNEDY. Today is truly a historic day for all Americans, and as an elected official of this great democracy, it is an extremely proud day for me. It is an occasion to celebrate and thank all those who fought to protect our nation’s democratic process. It is also an occasion to recognize and remember all those Americans who have suffered waiting for this day to arrive. We have worked together to achieve this goal of quality, affordable health care for all the people. I express my sincere gratitude, and I rejoice with you today that a new chapter in our history has begun.

The Affordable Health Care for America Act creates basic protections for all Americans seeking access to healthcare. No longer will insurers be able to drop you from your insurance when you get sick, nor can they deny you coverage for a pre-existing condition. A public option will offer a choice for consumers and provide real competition to keep private insurers honest. Affordability credits will help individuals pay the cost of purchasing health insurance. Additionally, these reforms are fully paid for and will actually lower the deficit over the next 10 years.

I am proud that the final version of this legislation includes numerous provisions I have long advocated for and worked with my colleagues to achieve. While the initial draft of the Affordable Health Care for America Act grossly closed the donut hole for Medicare prescription drug coverage last August, I am pleased to have worked with the Speaker to successfully reduce the timeline in which this critical reform will take place. The donut hole will now begin to close immediately and will close completely by 2019, providing much needed assurance and relief to seniors starting next year.

Likewise, I am also pleased that the Affordable Health Care for America Act eliminates lifetime caps, provisions of many health insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. I authored a letter, signed by 23 of my colleagues, urging this lifesaving provision to become effective immediately. I am pleased that the elimination of lifetime caps on insurance has been made effective in 2010, so that none of the 25 million individuals with lifetime caps each year will ever wait for the provisions to take place.

A key aspect of this legislation that is of particular importance to me is the extension of the mental health parity protections established in law last year. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Not only are these protections extended to all plans in the Health Insurance Exchange, but mental health and substance use benefits are a part of the essential benefits package created by this legislation. For 67 percent of adults and 80 percent of children needing mental health care that do not receive it, this victory cannot be understated. I commend my colleagues and my fellow citizens for their leadership in recognizing that the health of the mind truly cannot be separated from the health of the body. Today marks a new day and a giant leap forward towards our transition from a “sick care” system to one which is preventive, collaborative, and patient-centered.

Along these lines, I have also worked closely with my colleagues to ensure that mental health and substance use screening tools, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), were included in this legislation. Severe mental illnesses are estimated to cost the U.S. hundreds of billions annually in lost wages. Screening for mental health and substance use has proven to be a significant cost saver for our health care system. The Affordable Health Care for America Act establishes a program to provide grants to states to improve critical services.

I will continue to work with my colleagues to ensure that our health care professionals have the tools that are needed to recognize mental health and substance use in their patients. This means ensuring that mental health and substance use education be required of all health care professionals and integrated into the medical curricula, continuing medical education, and licensing examinations. It also includes addressing the drastic shortages of child and adolescent mental health professionals by providing loan forgiveness and matching grants to providers to develop, expand, and improve training programs for professionals who serve children and adolescents. Language to this effect is included in
some of the Senate healthcare reform legislation, and I will work with my colleagues to ensure that these critical provisions are retained.

Again, I commend my colleagues, the leadership, and my fellow Americans for their steadfast effort, diligence, and tremendous stewardship toward realizing the dream of quality, affordable health care for all Americans.

Mr. SMITH of New Jersey. Mr. Speaker, like most Americans, I believe we urgently need health care reform. I provide every American access to high-quality medical care.

During the long and painful illnesses of both my parents, I had to fight with their health management organization to get the care they deserved. Their HMO put my family through months of frustration and anguish. I know I’m not alone—tens of millions of Americans have gone through this as well. It’s not right, and it’s time to change that. Americans need more protection, power, and say in their health care programs, and they need us to reform the system to make it more affordable for everyone.

Regrettably, H.R. 3962, the bill before the House tonight, not only fails short, but it will make most people’s health care worse, and it will cost all of us. For this reason I strongly oppose the bill—H.R. 3962.

After carefully studying H.R. 3962, I am concerned that the bill is actually a step backward—many patients will have less, not more, access to and say over their health care if H.R. 3962 is enacted. I firmly believe we must reform our health care system and provide better solutions for those currently uninsured or underinsured. But we must do so without jeopardizing the quality of health care for these currently insured people and families, not all of whom will see their own health care access and quality seriously eroded under the bill.

H.R. 3962 will:

- Limit patient access by establishing federal bureaucracies with new authority to determine what medical treatments and services will be covered at, what costs patients will pay—Americans will be so disadvantaged that this bill makes those who don’t purchase “acceptable” coverage (as defined by the federal government) subject to criminal fines and imprisonment up to 5 years.

- Cause most Americans to lose access to their current health insurance coverage and force them into a nationally uniform public plan. It will do this by subsidizing a government-run “public plan” that will ultimately drive private health plans out of business. Most Americans don’t want to lose their current insurance, and they trust the public plan even less than they trust private insurance, which at least has to compete for customers, and permits them to fire their doctors. This would hit my constituents especially hard—according to the Urban Institute, approximately 90% of the people in my district currently have health care coverage.

- Slash payments to health-care providers, threatening the continued existence of many hospitals, home health and skilled nursing facilities serving New Jersey residents.

Madam Speaker, throughout my career in Congress, I have been a steadfast supporter of Medicare for our senior citizens and the disabled. I have voted several times to preserve and protect Medicare even when I stood alone in my own party rejecting a proposal to cut $270 billion from Medicare in 1995.

That is why I find it absolutely unacceptable that H.R. 3962 cuts Medicare by a whopping $500 billion. Proponents argue that some funding will be returned through other avenues. But even if that were true, Medicare will still be drastically cut by a net of $219.4 billion, in their “best case scenario.”

The bill also guts Medicare Advantage plans, which offer additional coverage to over 11 million seniors—15,983 in my district alone—who choose Medicare Advantage plans as the coverage that best meets their needs.

I will not vote for massive cuts in Medicare. These cuts will wreak havoc on our nation’s health care system and everyone it serves, particularly the seniors and disabled. We need reform legislation that respects all human life, the most vulnerable among us which includes the frail and the disabled of all ages.

Finally, this bill will hinder economic recovery and job creation during a major recession. Just yesterday the nation’s unemployment rate rose above 10 percent for the first time since 1983, and if you include those who have stopped looking for jobs those who are only part-time work, the rate is 17.5 percent. The bill does additional harm by:

- Raising taxes on individuals and small businesses by $729.5 billion;

- Failing to reform our costly and unfair system of medical liability laws, which inflates health care costs by billions of dollars each year, exceeding 10% of all health care expenditures;

- Mandating a $34 billion expansion of state Medicaid payments—in order to cover this massive increase in state spending, states like New Jersey will have to cut other services; and

- Costing the taxpayer, according to the Congressional Budget Office (CBO), $1.3 trillion over ten years and using budget gimmicks and tax increases to cover that cost.

I must mention two other serious problems with the bill:

- It does not adequately protect the freedom of conscience of health care providers opposed to abortion, and sets up mechanisms that ration care by creating government “wait lists” if there are insufficient funds to pay expenses; and

- It does not require patients to verify their identity, which, according to the CBO, means that millions undocumented immigrants will receive free health care, unfairly subsidized by taxpaying citizens.

It is truly unfortunate that the Democratic leadership did not work to put forth a health care reform bill that addressed these concerns. We need a proposal that advances solutions rather than creates new problems. Let me be clear, I take a back seat to no one when it comes to working to ensure that the federal government accepts its role and is doing its part in helping people and providing a health care safety net for those in desperate need of health care support. I am proud of my record voting to defeat cuts and to expand existing federal health care programs, while working to protect patient rights and the delivery of quality medical care. These efforts include:

- Medicare/Medicaid/SCHIP. I support providing our senior citizens a high level of benefits under the Medicare program. On one occasion, I voted against a $270 billion reduction in Medicare spending. One reason I cannot support the current health care legislation is because it makes over $500 billion in cuts to Medicare. To expand health insurance to more uninsured low-income children, I voted in 1997 for legislation creating the State Children’s Health Insurance Program (SCHIP) and voted last year to expand the program. SCHIP and Medicare/Medicaid together cover more than 30 million low-income children, as well as 16 million adults, 6 million seniors, and 10 million persons with disabilities. That is why I have been so adamant about protecting those programs.

Community Health Centers. Federally designated community health centers are another effective means to get affordable health care to underserved communities. The health centers program includes community, migrant, homeless, and public housing health centers and provides primary and preventive care to more than 18 million individuals at over 3,700 sites located in every state and U.S. territory. I have been a consistent supporter of increased funding for the community health centers program. A significant factor in the success of community health centers is that they are managed at the community level with a concern for serving their clients in their local neighborhoods.

Veterans Health Care. As former Chairman of the House Committee on Veterans’ Affairs, I fought successfully (and sometimes nearly alone) to provide increased medical services and funding for veterans health care programs. I wrote several laws to boost and expand veterans health care, including the Department of Veterans Affairs Health Care Programs Enhancement Act (PL 107–135), which expanded and enhanced veterans’ healthcare services and reduced out-of-pocket costs for low income veterans by 80 percent and continues to help disabled veterans obtain the tools they need to live fuller lives. I also wrote the law, the Veterans Health Programs Improvement Act of 2004 (PL 108–422), that created 5 poly-trauma centers within the VA, and an additional 17 networked sites, that specialize in treating complex injuries—including severe brain injury—associated with combat injuries from Iraq and Afghanistan.

Health Care Caucuses. Working with my colleagues across the aisle, I have co-founded and currently co-chair important bipartisan health care working groups, i.e. caucuses, which aim to educate Members of Congress and increase federal resources and research on treatments and cures for specific diseases, some which effect New Jersey residents disproportionately. For instance, I serve as co-chairman of the bipartisan Congressional Alzheimer’s Task Force; the Coalition for Autism Research and Education; the Spina Bifida Caucus; and the Lyme Disease Caucus. Each caucus has served as an effective forum to advance legislation that helps families combat health care challenges.

Patients Rights. As far back as 2001, I co-sponsored and voted for the Patient Protection Act which contained critical patient protections to help put doctors and patients back in control of their health care decisions, rather than bureaucrats at managed care companies. Unfortunatley, while serving as a bill passed the House and the Senate, they were never signed into law.

Insurance Reform. I voted for the Health Insurance Portability and Accountability Act of
1996 (HIPPA), which provided insurability pro-
tections for individuals moving between insur-
ance plans in the individual or group markets and
reduced or eliminated preexisting medical condi-
tion exclusion periods for such individ-
uals. I have also been a strong advocate for
allowing all small businesses, associations, and
non-profit organizations to be open to purchase
health insurance in acquiring health
insurance, small businesses do not enjoy the
benefits of economies of scale of large busi-
nesses, which allows those large businesses to
spread administrative costs over a large base
and thus have a significant leverage in negoti-
ating lower premiums. Over 50 percent of the
nation’s uninsured are employed in a small
business or are a dependent of such a worker.

Medical Malpractice Reform. The House of
Representatives has voted to pass medical li-
ability reform legislation with my support eight
times in the past 15 years. These bills—which
sought to place a cap on non-economic dam-
gages, limit punitive damages, and restrict at-
torneys’ fees—were modeled after a California
law that many credited for relatively low mal-
practice premiums in the state.

While we have had some significant suc-
cesses in these critical areas expanding—fre-
quently after much toil—it is indisputable that
more comprehensive changes are needed, in-
cluding major reforms of the private health in-
surance market.

The goal of responsible health care reform
should be to provide credible health insurance
coverage for everyone, strengthening the
health care safety net so that no one is left out,
and incentivizing quality and innovation, as
well as healthy behaviors and prevention. This
means that the current private health in-
surance market will have to be reformed to put
patients first, and to eliminate denials for pre-
existing conditions and lifetime caps and pro-
moting portability between jobs and geo-
graphic areas, including across state lines.
The tax code should be modernized to pro-
mote affordability and individual control, pro-
vide assistance to low-income and middle-
class families. Medicare requires reform to be
more efficient and responsive, with sustainable
payments.

Moreover, responsible health care reform
will respect basic principles of justice: it will
put patients and their doctors in charge of
medical decisions, not insurance companies or
government bureaucrats. It will also ensure
that the lives and health of all persons are re-
spected regardless of stage of development,
age or disability.

The Republican alternative amendment
does these things. It focuses on lowering
health care premiums for families and small
businesses, increasing access to affordable,
high-quality care, and promoting healthier life-
styles—without increasing taxes or adding to
the crushing debt Washington has placed on
our children and grandchildren and without
cutting Medicare. It also establishes a real
conscience protection for health care providers
and it requires verification of citizenship and
identity.

I oppose H.R. 3962 because in many ways
it jeopardizes coverage for those who already
have it, especially seniors and the disabled. At
the same time it exercises far too much top-
down government control, forcing everyone to
ward a government plan, controlling exactly
what sort of care will be offered. For this rea-
son I support the Republican alternative
amendment. It moves significantly in the right
direction while applying the wisdom of Hippoc-
rates’ first principle of medicine: doing no
harm.

AMENDMENT OFFERED BY MR. STUPAK.
Mr. STUPAK. Mr. Speaker, I have an
amendment at the desk.

The SPEAKER pro tempore. The
Clerk will designate the amendment.

The text of the amendment is as follows:

Part C amendment printed in House Rep-

Page 97, strike line 13 and all that follows
through page 98, line 7.

Page 110, strike lines 1 through 7.

Page 111, lines 2–14, strike “consistent with
subsection (e) of such section.”

Page 118, line 21, strike “(including sub-
section (e)).”

Page 154, after line 18, insert the following
new section (and conform the table of con-
tenTS of division A accordingly):

SEC. 265. LIMITATION ON ABORTION FUNDING.

(a) In General.—No funds authorized or
appropriated by this Act (or an amendment
made by this Act) may be used for any
abortion or to cover any part of the costs of
any health plan that includes coverage of
abortion, except in the case where a woman
suffers from a physical disorder, physical in-
jury, or physical illness that would, as cer-
tified by a physician before the bimanual
examination or danger of death unless an abortion is
performed, including a life-endangering physical
condition caused by or arising from the preg-
nancy itself, unless the pregnancy is the
result of an act of rape or incest.

(b) Option To Purchase Separate Supple-
mental Coverage or Plan.—Nothing in this
section shall prohibit any nonfederal entity (including an individual or
a State or local government) from pur-
chasing separate supplemental coverage for
abortion, for which funding is prohibited
under this section, or a plan that includes
such abortions, so long as:

(1) such coverage or plan is paid for enti-
tirely using only funds not authorized or
appropriated by this Act; and

(2) such coverage or plan is not purchased
using:

(A) individual premium payments required
for an Exchange-participating health benefits
plan towards which an affordability credit is
applicable; or

(B) other nonfederal funds required to re-
ceive a federal payment, including a State’s
or locality’s contribution of Medicaid match-
ing funds.

(c) Option To Offer Separate Supple-
mental Coverage or Plan.—Notwith-
standing section 308(b), nothing in this sec-
tion shall restrict any nonfederal QHP of-
fering entity from offering separate supple-
mental coverage for abortions for which
funding is prohibited under this section, or a
plan that includes such abortions, so long as:

(1) premiums for such separate supple-
mental coverage or plan are paid for entirely
with funds not authorized or appropriated by
this Act;

(2) administrative costs and all services of-
ferred through such supplemental coverage or
plan are paid for entirely with funds not au-
thorized or appropriated by this Act;

(3) any nonfederal QHP offering entity
that offers an Exchange-participating health
benefits plan that includes coverage for
abortions for which funding is prohibited
under this section also offers an Exchange-
participating health benefits plan that is
identical in every respect except that it
does not cover abortions for which funding is
prohibi-
language we have had since 1997. So I ask my colleagues, Democrats and Republicans alike, let us stand together on the principle of no public funding for abortion, no public funding for insurance policies that pay for abortion. Stand with us, protect our role, and let's keep current law.

I reserve the balance of my time.

Ms. DeGETTE. Mr. Speaker, I rise to claim the time in opposition to the Stupak-Pitts amendment.

The SPEAKER pro tempore. The gentleman from Colorado is recognized for 10 minutes.

Ms. DeGETTE. I yield myself 3 minutes, Mr. Speaker.

Mr. Speaker, to say that this amendment is a wolf in sheep’s clothing would be the understatement of a lifetime. The proponents say it simply extends the Hyde amendment, just a clarification of current law. Nothing could be further from the truth.

If enacted, this amendment will be the greatest restriction of a woman’s right to choose to pass in our careers.

Here is why: The Hyde amendment states that no Federal funds shall be used for abortions. This has been contained in our annual appropriations bills for many years.

In the Energy and Commerce Committee, the pro-choice and some pro-life Democrats came together and compromised and we said no Federal funds in this bill will be used for abortions, the Capps amendment. This bill does not spend one Federal dollar on abortions.

The Stupak-Pitts amendment goes much further. It says that as part of their basic coverage, the public option cannot offer abortions to anyone, even those purchasing the policies with 100 percent private money. The amendment further says that anyone who purchases insurance in the exchange and who receives premium assistance cannot get insurance coverage for a legal medical procedure even with the portion of their premium that is their own private money.

Well, the proponents say women can just purchase supplemental insurance for abortions. This very notion is offensive to women. No one thinks that women will have an unplanned pregnancy or a planned pregnancy that goes wrong. Would we expect to have people buy supplemental insurance for cancer treatment just in case maybe they might get sick? Like it or not, this is a legal medical procedure, and we should respect those who need to make this very personal decision.

Once again, the base bill contains language that preserves the Hyde amendment. Let’s keep our eyes on the goal here, providing safe medical treatment for 36 million Americans. Let’s not sacrifice reproductive rights today in pursuit of another goal.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield myself 1 ¼ minutes.

I rise in support of this bipartisan amendment. Polls have repeatedly shown that the public does not support Federal funding of abortion, yet that is exactly what is in this bill. Current law actually prohibits any Federal health care plan from paying for abortion. It also prevents taxpayer subsidies from flowing to benefit packages that include abortion. However, the Capps amendment included in this legislation would have the opposite effect.

Under this amendment, funding will flow from premium payments and affordability credits into the U.S. Treasury account, and that account will then reimburse for abortion services. Every dollar in the public option is a Federal dollar. Let me be clear, if the government plan covers abortion, that amounts to Federal funding for abortion. It’s that simple.

Our amendment would maintain the principles of the Hyde amendment, something that the large majority of Americans support. Our amendment would prohibit Federal funding for abortions. This very notion is offensive. In the Congress of the United States, we have a responsibility to respect the moral beliefs of the majority of the American people.

Ms. DeGETTE. I am now delighted to yield 1 minute to the gentlelady from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I rise in strong opposition to this amendment. Contrary to what its sponsors and their supporters say, the underlying bill does prohibit Federal funding for abortion. It is written clearly and plainly on page 246, line 11, “prohibition of use of public funds for abortion coverage.” But apparently that isn’t good enough for people whose goal really is to strip women of their right to choose altogether despite purporting to just want to maintain the status quo. So instead we have this amendment which restricts a woman’s right to access a legal medical procedure in this country.

It is ironic, actually, because most of the people who support the amendment claim to oppose government interference in health care, yet this amendment is government interference and a decision that should be made between a woman and her physician.

If this amendment passes, it will be the first language in any legislation that actually restricts coverage of a legal medical procedure. Not one other legal medical procedure is singled out in this legislation for rationing.

I urge my colleagues to vote “no” on this devastating amendment.

Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentleman from Indiana, Chairman Mike PENCE.

Mr. PENCE. Mr. Speaker, I rise in support of this amendment, though it will not change my opposition to the Pelosi health care bill. I am grateful this amendment has been brought to the floor, and I wish to commend Mr. Pitts and Mr. Stupak for their principled leadership.

Ending an innocent human life is morally wrong, but it’s also morally wrong to take the taxpayer dollars of millions of Americans and use them to provide for a procedure that they find morally offensive. In the Congress of the United States, we have a responsibility to respect the moral beliefs of the majority of the American people.
I urge my colleagues to prevent Federal dollars from funding abortions. Take a stand for life, support the Stupak-Pitts amendment, and vote “no” on Pelosi’s health care.

Ms. DEGETTE. I yield 1 minute to the distinguished gentlelady from New York (Mrs. LOWEY).

Mrs. LOWEY. I rise in strong opposition to this amendment. This is a disappointing distraction from the bill before us.

Under current law, no taxpayer funds can be used to cover abortion. While I believe abortion should be legal and safe, I have worked for years with colleagues on both sides of this issue to make this procedure rare. If we want to reduce abortions, we should provide women health coverage for reproductive care, contraceptives to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.

This amendment threatens the rights and health of women to seek a legal procedure covered by the premiums they will pay out of their own pockets. The underlying bill would uphold current law which states that no Federal funds can support abortion. Therefore, I urge my colleagues to oppose this unnecessary and reprehensible amendment.

Mr. STUPAK. Mr. Speaker, may I inquire as to how much time we have remaining?

The SPEAKER pro tempore. The gentleman from Michigan has 3/4 minutes remaining. The gentlewoman from Colorado has 4½ minutes remaining. The gentleman from Pennsylvania has 3½ minutes remaining.

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

Ms. DEGETTE. Mr. Speaker, I reserve.

Mr. PITTS. Mr. Speaker, at this time, I yield to the gentlelady from Washington, Vice Chairwoman CATHY MCMorRIS RODGERS.

Mrs. RODGERS. Mr. Speaker, many have stood before me from both sides of the aisle to ensure that Federal taxpayer dollars do not fund abortion, whether it’s Medicaid, whether it’s the Federal Government’s own health program. Today, I stand to ensure that this policy is included in the health care bill that is being rammed through this Congress.

If we are talking about health care reform for women and children, then protecting women should start at the moment their life begins. Two-thirds of women recently polled representing all parties, races, and marital statuses object to government funding of abortion.

I urge my colleagues to support this amendment.

Mr. STUPAK. Mr. Speaker, I yield 1 minute to Mr. ELLSWORTH from Indiana, who has been a champion on this issue and has worked hard to get this amendment to where we are here today.

Mr. ELLSWORTH. Thank you, Mr. STUPAK.
Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentlewoman from Minnesota, MICHIE BACHMANN.

Mrs. BACHMANN. Mr. Speaker, it all begins with life and with protecting the most vulnerable among us, the unborn. Life is the watershed issue of our generation. How can one claim to call the destruction of innocent human life ‘health care’?

Orwellian statements aside, it is the duty of government to preserve and protect human life. If we do nothing else tonight, let’s choose life.

Ms. DEGETTE. I inquire of the Speaker as to the time remaining.

The SPEAKER pro tempore. The gentlewoman from Minnesota, Distinguished Chair of the Pro-Choice Caucus, the gentlewoman from Michigan has 2½ minutes. The gentleman from Pennsylvania has 2 minutes remaining.

Ms. DEGETTE. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Illinois (Mr. QUIGLEY).

Mr. QUIGLEY. Mr. Speaker, the health care we are considering today makes a strong statement that everyone in this country deserves access to health care.

For over 8 months, this body has strived to overcome the health care inequities that exist in our country, but this amendment disrupts that sense of equality. This amendment says that only women who can afford insurance deserve access to reproductive health care. This amendment says that women who lack a little help paying for health care have to surrender their right to privacy.

This amendment will serve only to hurt low-income women, and it will restrict their ability to access reproductive health care. This amendment says that women who lack a little help paying for health care have to surrender their right to privacy.

This amendment will serve only to hurt low-income women, and it will restrict their ability to access reproductive health care. This amendment says that women who lack a little help paying for health care have to surrender their right to privacy.

I want to thank Mr. STUPAK and Mr. PITTS for this amendment to prohibit Federal funding for abortion in the guise of health care reform. Women deserve better.

Last week, we heard a lot of talk about compromise. Well, Mr. Speaker, neither a child in an early phase of life nor an employer or a consumer of health care deserves to be subject to a compromise. I hope that, if House has learned anything from this debate, it is this: that we must first do no harm. It is not ours to decide who lives or who dies.

Ms. DEGETTE. Mr. Speaker, I am now delighted to yield 30 seconds to the distinguished Chair of the Rules Committee and the co-Chair of the Congressional Pro-Choice Caucus, the gentlewoman from New York (Ms. SLAUGHTER).

Ms. SLAUGHTER. I thank the gentlewoman for yielding.

Mr. Speaker, for over 30 years, we lived in this House in peaceful co-existence with the pros and cons getting together on the fact that the Hyde amendment said that no Federal money can be spent—the strongest conscience clause in the world—which is now being strengthened, by the way, in this bill. We on this side simply have the law.

I am very concerned about this bill because, in my own case and in the cases of many of my colleagues, it means 30 or 40 years of our life is being canceled out with this amendment. After the things that we have fought for, we are driving now, I am afraid, young women and poor women who cannot afford to buy their own insurance policies out of their pockets back to the back alley. I dread to see that day.

Mr. PITTS. Mr. Speaker, we are prepared to close on our side.

Ms. DEGETTE. Mr. Speaker, I yield for a response on the amendment request to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN asked and was given permission to revise and extend her remarks.

Ms. BALDWIN. Mr. Speaker, I rise in opposition to this amendment.

A journalist asked me a few years ago if I could point to one thing that has contributed the most to the empowerment of women in our society. In answer to that query, I might point to the 19th Amendment to the Constitution giving women the right to vote, or Title VII of the Civil Rights Act of 1964, or laws mandating equal pay for equal work. But instead, I responded to that journalist that it is the array of legal choices a woman now has that make it possible for her to plan her family—to decide whether to have children, and to decide when to have children. We refer to this array of choices as “reproductive freedom.”

In the days before women were able to legally access contraception and abortion services, women often had to drop out of school, few could pursue careers in the professions, and too many women in desperate circumstances lost their lives from so-called back-alley abortions.

In 1970 women made up a third of the workforce. Today for the first time in history, women make up half of the U.S. workforce. In 1970, ten women served in the House of Representatives. Today there are 76. In 1970, the percentage of female medical students was 9.6 percent. This year, women are 48 percent of our Nation’s medical students. In 1970, the percentage of women in law school was 8 percent. Today, 46.7 percent of law students are female.

These are just some of the changes in the role of women in American society that have occurred over the years during which women have secured the right to a full range of family planning options.

The Stupak/Pitts amendment is an erosion of a woman’s reproductive freedom. Access to abortion services in the United States is already severely limited. State laws mandating the lack of insurance coverage of abortion and the scarcity of clinics providing abortion services mean that the right to a safe and legal abortion for many women is already pretty hollow. If this amendment is adopted, a woman’s right to choose will be further limited.

I urge my colleagues to oppose this amendment.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentleman from New York (Mrs. MALONEY).

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

Mrs. MALONEY. Mr. Speaker, I rise in strong opposition to this amendment.

Mr. Speaker, it is outrageous that even the historic bill to extend health coverage to 96 percent of Americans includes an abortion fight because of the anti-abortion movement.

The Stupak amendment is a huge step backwards for American women.

Mr. Speaker, I rise in strong opposition to the Stupak/Pitts amendment which plainly discriminates against women, puts women’s health at risk, and marks an unprecedented determination on people who pay for their own health insurance.

The commonsense Capps Compromise which was agreed to during debate in the Energy and Commerce Committee ensures that taxpayers will not be paying for abortion and redefines status quo and consciousness.

It prohibits federal funds from being used for abortion but still allows women to use their own money to buy the coverage they need.

Despite this effort to address concerns raised by pro-life Members, Representatives from across the spectrum decided to further restrict women’s access to care by offering their shortsighted, dangerous, and discriminatory amendment to H.R. 3962.

The Stupak/Pitts amendment would make abortion coverage virtually inaccessible for most women in the new exchange.

It does so by:

(1) Banning abortion coverage in the exchange for women who receive subsidies, except by separate rider that they could only purchase with their own, private funds.

(2) Making it highly unlikely that women buying insurance in the exchange with their own money could obtain abortion coverage.

It is an outrage that at time when we are making historic changes—expanding America’s access to health care—a group of legislators are bending together to deprive women of the very health care they both need and deserve.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentleman from Maryland (Ms. EDWARDS).

(Ms. EDWARDS of Maryland asked and was given permission to revise and extend her remarks.)

Ms. EDWARDS. Mr. Speaker, I rise in strong opposition to this amendment.

Ms. DEGETTE. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAOKWSKY).

Ms. SCHAOKWSKY. No matter how many times it is said, our health reform bill does not allow one Federal dollar for abortions.

This Stupak-Pitts amendment goes way beyond current law. It says a
woman cannot purchase, using her own dollars, coverage that includes abortion services. Even middle class women who are using exclusively their own money will be prohibited from purchasing a plan including abortion coverage, and this is in every single public or private plan in the new health care exchange. Her only option is to buy a separate insurance policy that covers an abortion, a ridiculous and unworkable approach since no woman plans an unplanned pregnancy. "This amendment is a radical departure from current law, and it will result in millions of women losing the coverage they already have. Our bill is about lowering health care costs for millions of women and their families. It is not about further marginalizing women by forcing them to pay more for their care.

This amendment is a disservice and an insult to millions of women throughout the country. I urge a "no" vote on this amendment.

The SPEAKER pro tempore. The Chair will remind the gentlewoman from Colorado that she has the right to close.

The gentleman from Michigan has 1 ¼ minutes remaining. The gentleman from Pennsylvania has 1 ½ minutes remaining. The gentlewoman from Colorado has 30 seconds remaining.

Mr. STUPAK. Mr. Speaker, I yield 15 seconds to the gentleman from Illinois (Mr. PITTS), to state how current laws are maintained with the Stupak amendment.

Mr. LIPINSKI. Mr. Speaker, I thank my colleagues, especially Mr. STUPAK, for their perseverance as we work together on this amendment. Every year for over three decades, including this past July, we have approved the Hyde amendment.

I ask my colleagues again tonight: do we really want to see more abortions and if we want to reduce them, don't fund it.

The Guttmacher Institute has said, formerly the research arm of Planned Parenthood, that prohibiting Federal funds for abortion reduces abortion by 25 percent.

Millions of people are alive today because of the Hyde amendment, because funding was not there to effectuate their demise. Vote for the Stupak-Pitts amendment. It will save lives.

The SPEAKER pro tempore. The gentleman from Michigan has 1 minute remaining.

Mr. STUPAK. Mr. Speaker, to close on this side, I yield 1 minute to the gentlewoman from Ohio (Ms. KAPTUR). Ms. KAPTUR. I thank the gentleman.

With respect for all of my colleagues, I rise in support of the Stupak amendment, which maintains existing Federal law, the Hyde amendment, on the compelling issue of abortion.

For 34 years, citizens of conscience have weighed in on this important moral and legal issue. Let me repeat: This amendment reaffirms longstanding existing law and nothing more. It represents the broad consensus of the American people after 34 years of consideration on this issue. This is what it says:

"No Federal funds authorized under this act may be used to pay for any abortion or cover any part of the costs of any health plan that includes coverage of abortion, except in the cases of the life of the mother, rape or incest." The amendment does no more, no less. It represents the broad consensus of the American people after 34 years of consideration on this issue. This is what it says:

"No Federal funds authorized under this act may be used to pay for any abortion or cover any part of the costs of any health plan that includes coverage of abortion, except in the cases of the life of the mother, rape or incest." The amendment does no more, no less. It represents the broad consensus of the American people after 34 years of consideration on this issue. This is what it says:

"No Federal funds authorized under this act may be used to pay for any abortion or cover any part of the costs of any health plan that includes coverage of abortion, except in the cases of the life of the mother, rape or incest."
and her doctor. This is an instance where the federal government does not need to be involved. It is my hope that society will continue to be progressive in their decisions, and if a woman decides to terminate her pregnancy, there are places that she can go to have the procedure done safely, expeditiously, and with no discrimination or danger to women's health. Women without abortion coverage will be forced to postpone abortion care while attempting to raise the necessary funds—a delay that can exacerbate both the costs and the health risks of the procedure.

As a woman, I find it frankly insulting that the amendment would make women purchase additional insurance coverage for a legal medical procedure. We aren't asking individuals to purchase additional coverage in case they get cancer or in case they get diabetes. We aren't flagging out any other legal medical procedures to be treated in this manner.

Women do not plan to have unintended pregnancies or pregnancies with complications that limit their access to a healthy pregnancy. It is estimated that one third of Americans will have an abortion in their lifetime. If this amendment is passed, every woman covered under the new health care system would have to purchase supplemental insurance or pay out of pocket for abortions. It is estimated that one third of Americans will have an abortion in their lifetime. If this amendment is adopted, thousands of women will be unable to afford a procedure for unpredictable and unwanted pregnancies. This would essentially be a ban on abortions for these women.

This is an unacceptable violation of a woman's personal sovereignty. I strongly oppose this amendment.

Ms. DeGETTE. Mr. Speaker, the gentleman from Pennsylvania said exactly what the intention is here. The intention is not simply to expand the Hyde amendment. The base bill does that. The base bill says that no Federal credits—can be used to pay for abortion procedures.

Before taking this vote, I urge my colleagues to support this amendment to think about the women in their lives, their mothers, sisters, daughters, granddaughters. Would they put the lives of these women at risk? Would they take away their fundamental rights of choice and freedom? Would they want to limit their access to safe, legal, and ethical procedures? I ask these questions of my colleagues because in voting in support of the Stupak Amendment, they are answering yes to all these questions.

I urge my colleagues to join me in voting "no" on the amendment.

Ms. HARMAN. Mr. Speaker, It is going to be very difficult for me to vote for a health care bill that contains the Stupak amendment on abortion.

Far from codifying the Hyde language, which has been included in House appropriations bills since 1976, the Stupak amendment would essentially make it impossible for most women to use their own funds to purchase insurance to pay for abortions. This is not chipping away at a woman's right to choose, this is an outright assault on my constitutional rights—and it is wrong.

I respect the right of any woman or man to oppose abortion. But, in return, I expect those who are anti-choice to respect my views. My views are both, that women are safe and rare—but that a woman's constitutional right to privacy as articulated in Roe v. Wade is inviolable.

I am old enough to remember the days of back alley abortions. Some women I know had these procedures. I cannot bear the idea that the 111th Congress would restore that horror.

The Stupak Amendment is insulting and de-structive. Its passage would pair us with the government of Afghanistan in sending women's rights back to the Stone Age. I intend to vote for this bill, but if it contains the Stupak amendment when it emerges from Conference Committee, my conscience demands that I reconsider my support.

Ms. McCOLLUM. Mr. Speaker, every member of this House has the right to their own opinions and views on issues related to health care reform—including women's reproductive health care issues. However, as comprehen-sive national health care legislation moves closer to the floor for a vote, Congress must not violate the first tenant of the entire reform effort, which is to ensure that no one loses healthcare coverage they currently have.

Today we have an amendment on the floor that bans legal reproductive health care services for women who pay for their own health insurance. This amendment is wrong, it is dangerous, and it should be defeated.

The opportunity to meet the health care needs of Americans is the strength of the bill we are debating. I want every American to have access to affordable, quality health care. This amendment and the work of many special interest groups to use this amendment to undermine health care reform is a transparent political game that puts Americans at risk. Single issue political games must not be used to deny health care to millions of Americans.

I would like to submit for the RECORD a statement by a broad coalition of Minnesota religious leaders who call health care reform a matter of social justice that should not be undone by a single issue. These religious leaders understand the complex personal decision making that goes into health care choices, but they also know that Americans without access to health care too often have no choice except to suffer and too often endure conditions that result in severe illness or even preventable death.

These religious leaders are an inspiration to me. They are helping to frame the social, eco-nomic, moral and spiritual importance of pass-ing health care reform legislation in Congress.
It's simply untrue that abortion coverage will be mandated under the proposed new health plan. Simply put, Federal money would not pay for abortion care.

In addition, the Capps bill contains carefully crafted compromise language that allows women to keep the benefits they currently have while ensuring that no federal funding is used for abortions.

Rep. Lois Capps drafted this provision to address both pro-life and pro-choice concerns around health care reform and balance both sides of the issue. The Capps proposal maintains the current policy of restricting federal funding for abortions and ensures that women and their doctors have and will have access to insurance that covers abortion if they want it. Further, it expressly prohibits the use of federal funds to pay for abortions.

This is an even-handed compromise supported by people on both sides of the issue. While reasonable people disagree over the issue of abortion, no woman wants her health to be the object of political gamesmanship in this debate. That's why the Capps proposal was created. It's a common sense solution that the health care reform move forward with the support of the mainstream on all sides of the issue.

As the House debates, we support public policies that are just and compassionate and prioritize the needs of those who are poor and marginalized in our society. In this religious tradition, our health care system should be inclusive and respectful of diverse religious beliefs and decisions regarding childbearing. A health care system that serves all persons with dignity and equality will include comprehensive reproductive health services.

Health care reform is far too important a social issue to be left to chance and be overtaken by overheated rhetoric. It's time to move forward for the good of American women and families.

Members and Friends of the Minnesota Religious Coalition for Reproductive Choice: Rev. Judith Allen Kim, Presbytery of the Twin Cities Area; The Rev. Norma Burton, Linden Hills United Church of Christ, Minneapolis; Kelli Clement, Candidate for Minnesota, UUA; Rev. Doug Donley, University Baptist Church, Minneapolis; Rev. Dr. Rob Eller-Isaacs, Co-Ministers, Unity Church Unitarian, St. Paul; Rev. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Lockhart IV, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kiely Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Christine M. Smith, Cherokee Park United Church, St. Paul; Rev. Victoria Safford, Hennepin Unitarian Universalist Church, Mahtomedi; Rabbi Jared Saks, Temple Israel, Minneapolis; Barbara Schmichchen, Linden Hills United Church of Christ, Minneapolis; and Democratic leadership, along with 182 of their colleagues, to allow members of the public to have their say with regard to abortion and health care reform by allowing consideration of an amendment to prohibit government funding of abortion.

Ms. BORDALLO. Mr. Speaker, I rise today in support of the Stupak-Ellsworth-Pitts-Smith amendment to H.R. 3962 the “Affordable Health Care for America Act.” This amendment, supported by the United States Conference of Catholic Bishops, is important because it ensures that current federal law on abortion funding will apply to the public health care option created by H.R. 3962.

This amendment codifies the Hyde Amendment in H.R. 3962. It will prevent public funds from being used to pay for or subsidize elective abortions, either through the public option or health care affordability tax credits, except in the case of life threatening injury or physical illness to the women. The Hyde Amendment is already in place in current federal health programs like Medicaid and Medicare and this amendment will make sure that H.R. 3962 is governed in a consistent manner.

I have received numerous letters from my constituents expressing both support for health care reform, but also grave concerns that federal funds would be used to pay for elective abortion under the new law. I am very supportive of the overall goals of H.R. 3962 and particularly its provision that addresses the health disparity issues in the territories. The addition of the Stupak-Ellsworth-Pitts-Smith-Kaptur-Dahlemper amendment will further strengthen this legislation and ensure that no one will need to choose between their conscientious objections to abortion and their desire to work toward more affordable quality health care in America.

I commend Congressman STUPAK for his leadership on this important issue and urge my colleagues to support this amendment.

Mr. FAHR. Mr. Speaker, I rise to express my strong opposition to the Stupak-Pitts amendment.

The health care bill before the House tonight retains existing law on the ban on federal dollars being used for abortion services in federal programs. This health care bill does what it promised to do: not to expand abortion services. But the Stupak amendment wants to rewrite current law. This amendment ignores the constitutionally protected right for women to choose their reproductive health care. It makes women, and only women, have to purchase health care insurance to cover a health care procedure that can only be needed at a time of crisis. It would require women to plan for an unplanned pregnancy. That is plain wrong.

When will we stop treating women like second-class citizens? When will we admit that they have the right to determine their health care like anyone else? Why are we boxing them in with this amendment that restrains their ability to act in a manner they deem appropriate for their well-being? Shame on us for being so disrespectful of their humanity and for attempting to disenfranchise them this way.

If we want health care for all Americans then women should be entitled to all health care, not just some. As House Speaker Pelosi announced that the noes appeared to have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. The question is on the amendment offered by the gentleman from Michigan (Mr. STUPAK).

The question was taken; and the SPEAKER pro tempore announced that the nays had it.

Mr. BOEHNER. Mr. Speaker, pursuant to the rule, I call up the amendment in the nature of a substitute printed in the rule.

The Speaker pro tempore (Mr. OBEXER). The Clerk will designate the amendment.

The text of the amendment is as follows:

Part D amendment in the nature of a substitute printed in House Report 111-390 offered by Mr. Broun: Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; PURPOSE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Common Sense Health Care Reform and Affordability Act”.

(b) Purpose.—The purpose of this Act is to take meaningful steps to lower health care costs and increase access to health insurance coverage (especially for individuals with preexisting conditions) without—

(1) raising taxes;
(2) cutting Medicare benefits for seniors; and
(3) adding to the national deficit;

(4) interfering in the doctor-patient relationship; or

(5) instituting a government takeover of health care.

(c) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; purpose; table of contents.

DIVISION A—MAKING HEALTH CARE COVERAGE AFFORDABLE FOR EVERY AMERICAN

TITLE I—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

Sec. 101. Establish universal access programs to improve high risk pools and reinsurance markets.

Sec. 102. Elimination of certain requirements for guaranteed availability in individual market.

Sec. 103. No annual or lifetime spending caps.

Sec. 104. Preventing unjust cancellation of insurance coverage.

TITLE II—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

Sec. 111. State innovation programs.

Sec. 112. Health plan finders.

Sec. 113. Administrative simplification.
DIVISION B—IMPROVING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES
Sec. 201. Rules governing association health plans.
Sec. 203. Enforcement provisions relating to association health plans.
Sec. 204. Cooperation between Federal and State authorities.
Sec. 205. Effective date and transitional and other rules.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS
Sec. 211. Extending coverage of dependents.
Sec. 212. Allowing auto-enrollment for employment-sponsored coverage.

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO BUY HEALTH CARE COVERAGE ACROSS STATE LINES
Sec. 221. Interstate purchasing of Health Insurance Accounts.

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS
Sec. 231. Saver's credit for contributions to health savings accounts.
Sec. 232. HSA funds for premiums for high deductible health plans.
Sec. 233. Requiring greater coordination between HDHP administrators and HSA account administrators so that enrollees can enroll in both at the same time.
Sec. 234. Special rule for certain medical expenses incurred before establishment of account.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM
Sec. 301. Encouraging speedy resolution of claims.
Sec. 302. Compensating patient injury.
Sec. 303. Maximizing patient recovery.
Sec. 304. Additional health benefits.
Sec. 305. Punitive damages.
Sec. 306. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 307. Definitions.
Sec. 308. Effect on other laws.
Sec. 307. Definitions.
Sec. 305. Punitive damages.
Sec. 302. Compensating patient injury.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
Sec. 401. Rule of construction.
Sec. 402. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS
Sec. 501. Incentives for prevention and wellness programs.

DIVISION F—PROTECTING TAXPAYERS
Sec. 601. Provide full funding to HHS OIG and HCFAC.
Sec. 602. Prohibiting taxpayer funded abortions and conscience protections.
Sec. 603. Improved enforcement of the Medicare and Medicaid secondary payer provisions.
Sec. 604. Strengthen Medicare provider enrollment standards and safeguards.
Sec. 605. Targeting banned providers across State lines.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS
Sec. 701. Licensure pathway for biosimilar biological products.
Sec. 702. Fees relating to biosimilar biological products.

SEC. 703. Amendments to certain patent provisions.

DIVISION A—MAKING HEALTH CARE COVERAGE AFFORDBALE FOR EVERY AMERICAN

TITLE I—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS
SEC. 101. ESTABLISH UNIVERSAL ACCESS PROGRAM TO IMPROVE HIGH RISK POOLS AND REINSURANCE MARKETS.
(a) STATE REQUIREMENT.—
(1) IN GENERAL.—Not later than January 1, 2010, each State shall—
(A) subject to paragraph (3), operate—
(i) a qualified State reinsurance program described in subsection (b); or
(ii) qualifying State high risk pool described in subsection (c)(1); and
(B) subject to paragraph (3), apply to the operation of such a program from State funds an amount equivalent to the portion of State funds derived from State premium assessments (as defined by the Secretary) that are not otherwise used on State health care programs.
(2) RELATION TO CURRENT QUALIFIED HIGH RISK POOL PROGRAM.—
(A) STATES NOT OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is not operating a current section 2745 qualified high risk pool on the date of the enactment of this Act—
(i) the State may only meet the requirement of paragraph (1) through the operation of a qualified State reinsurance program described in subsection (b); and
(ii) the State's operation of such a reinsurance program shall be treated, for purposes of section 2745 of the Public Health Service Act, as the operation of a qualified high risk pool described in such section.
(B) STATE OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is operating a current section 2745 qualified high risk pool on the date of the enactment of this Act—
(i) the State may only meet the requirement of paragraph (1) through the operation of a qualified State reinsurance program described in subsection (b); and
(ii) the State’s operation of such a reinsurance program shall be deemed to be operation of such a pool to operation of a qualified State reinsurance program described in subsection (b).

(3) APPLICATION OF PROVISIONS.—If the program or pool operated under paragraph (1)(A) is in strong fiscal health, as determined in accordance with standards established by the National Association of Insurance Commissioners and as approved by the State Insurance Commissioner involved, the requirement of paragraph (1)(B) shall be deemed to be met.

(b) QUALIFIED STATE REINSURANCE PROGRAM.—
(1) IN GENERAL.—For purposes of this section, a “qualified State reinsurance program” means a program operated by a State program that provides reinsurance for health insurance coverage offered in the small group market in accordance with the model for such a program established (as of the date of the enactment of this Act).
(2) FORM OF PROGRAM.—A qualified State reinsurance program may provide reinsurance—
(A) on a prospective or retrospective basis; and
(B) on a basis that protects health insurance issuers against the annual aggregate spending of their enrollees as well as purchaser protection against individual catastrophic costs.

(c) SATISFACTION OF HIPAA REQUIREMENT.—A qualified State reinsurance program shall be deemed, for purposes of section 2745 of the Public Health Service Act, to be a qualified high-risk pool under such section.

(d) QUALIFYING STATE HIGH RISK POOL.—
(1) IN GENERAL.—A qualifying State high risk pool described in subsection (c)(1) means a current section 2745 qualified high risk pool that meets the following requirements:
(A) The pool must provide at least two coverage options, one of which must be a high deductible health plan coupled with a health savings account.
(B) The pool must be funded with a stable funding source.
(C) The pool must eliminate any waiting lists so that all eligible residents who are seeking coverage through the pool should be allowed to receive coverage through the pool.
(D) The pool must allow for coverage of individuals who, but for the 24-month disability waiting period under section 226(b) of the Social Security Act, would be eligible for Medicare during the period of such waiting period.
(E) The pool must limit the pool premiums to no more than 150 percent of the average premium for applicable standard risk rates in that State.
(F) The pool must conduct education and outreach initiatives so that residents and brokers understand that the pool is available to eligible residents.

(2) RELATION TO CURRENT QUALIFIED HIGH RISK POOL PROGRAM.—
(A) STATES REQUIREMENT.—
(i) EACH STATE.—Notwithstanding any other provision of law, only citizens and nationals of the United States shall be eligible to participate in a qualifying State high risk pool that receives funds under section 2745 of the Public Health Service Act or this section.

(ii) SATISFACTION OF HIPAA REQUIREMENT.—
(A) IN GENERAL.—Notwithstanding any other provision of law, only citizens and nationals of the United States shall be eligible for coverage in the qualifying State high risk pool to provide satisfactory documentation of citizenship or nationality in a manner consistent with section 1902(x) of the Social Security Act.

(B) RECORDS.—The Secretary shall keep sufficient records such that determination of citizenship or nationality only has to be made once for any individual under this paragraph.


SEC. 102. FUNDING.—In addition to any other amounts appropriated, there is appropriated—
(1) $15,000,000,000 for the period of fiscal years 2010 through 2016 and
(2) an additional $10,000,000,000 for the period of fiscal years 2017 through 2019.

SEC. 103. DEFINITIONS.—In this section:
(1) *Health insurance coverage; health insurance issuer.*—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms in section 2711 of the Public Health Service Act.

(2) **Current section 2745 qualified high risk pool.**—The term “current section 2745 qualified high risk pool” has the meaning given the term “qualified high risk pool” under section 2745(g) of the Public Health Service Act as in effect as of the date of the enactment of this Act.

(3) **Secretary.**—The term “Secretary” means Secretary of Health and Human Services.

(4) **Standard risk rate.**—The term “standard risk rate” means a rate that—

(A) is determined under the State high risk pool by considering the premium rates charged by other health insurance issuers offering health insurance coverage to individuals in the insurance market served;

(B) is established using reasonable actuarial techniques; and

(C) reflects anticipated claims experience and expenses for the coverage involved.

(5) **State.**—The term “State” means any of the 50 States or the District of Columbia.

**SEC. 102. Elimination of certain requirements for guaranteed availability in individual market.**

(a) In general.—Section 2741(b) of the Public Health Service Act (42 U.S.C. 300gg–41(b)) is amended—

(1) in paragraph (1)—

(A) by striking “(1)(A)” and inserting “(1)”; and

(B) by striking “(and)” and all that follows up to the semicolon at the end;

(2) by adding “and” at the end of paragraph (2);

(3) in paragraph (3)—

(A) by striking “(1)(A)” and inserting “(1)”; and

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

(4) by striking paragraphs (4) and (5).

(b) Effective date.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

**SEC. 103. No annual or lifetime spending caps.**

Notwithstanding any other provision of law, a health insurance issuer (including an entity licensed to sell insurance with respect to a State or group health plan) may not apply an annual or lifetime aggregate spending cap on any health insurance coverage or plan offered by such issuer.

**SEC. 104. Preventing unjust cancellation of insurance coverage.**

(a) Clarification regarding application of guaranteed renewal of individual health insurance coverage.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42) is amended—

(1) in its heading, by inserting “, continuation in force, including prohibition of rescission,” after “guaranteed renewability”;

(2) in subsection (a), by inserting “, including without rescission,” after “continue in force”; and

(3) in subsection (b)(2), by inserting before the period at the end the following: “, including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed.”

(b) Opportunity for independent, external third party review in certain cases.—

(1) Notice and review right.—If a health insurance issuer determines to nonrenew or not to renew, continue in force, including rescind, health insurance coverage for an individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary, the individual shall provide the issuer with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

(2) Independent determination.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2)."

(c) Effective date.—The amendments made by this section shall apply after the date of the enactment of this Act with respect to health insurance coverage issued before, on, or after—

**TITLE II—Reducing health care preeminent cost and the number of uninsured Americans**

**SEC. 111. State innovation programs.**

(a) Programs that reduce the cost of health insurance premiums.—

(1) Payments to states.—

(A) For premium reductions in the small group market.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the small group market in year 3, in year 6, or year 9 (as defined in subsection (c)) below the premium baseline as defined in paragraph (2), the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage (as defined in paragraph (3) for the State, market, and year; and

(ii) the maximum State premium payment amount (as defined in paragraph (4) for the State, market, and year).

(B) For premium reductions in the individual market.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the individual market in year 3, in year 6, or in year 9 below the premium baseline for such year, the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage (as defined in paragraph (3) for the State, market, and year; and

(ii) the maximum State premium payment amount for the State, market, and year.

(2) Premium baseline.—For purposes of this subsection, the term “premium baseline” means, for a market in a State—

(A) for year 1, the average per capita premiums for health insurance coverage in such market in the State in such year; or

(B) for a subsequent year, the baseline for the market in the State for the previous year under this paragraph increased by a percentage specified in accordance with a formula established by the Secretary, in consultation with the Congressional Budget Office and the Bureau of the Census, that takes into account at least the following:

(i) Growth factor.—The inflation in the costs of inputs to health care services in the year.

(ii) Historic premium growth rates.—Historic growth rates, during the 10 years before year 1, of per capita premiums for health insurance coverage.

(iii) Demographic considerations.—Historic average changes in the demographics of the population covered that impact on the rate of growth of per capita health care costs.

(3) Bonus premium percentage defined.—

(A) In general.—For purposes of this subsection, the term “bonus premium percentage” means, for the small group market or individual market in a State for a year, such percentage as determined in accordance with the following table based on the State’s premium performance level (as defined in subparagraph (B)) for such market and year:

<table>
<thead>
<tr>
<th>Bonus Percentage Level</th>
<th>Year 3 if Premium Performance Level</th>
<th>Year 4 if Premium Performance Level</th>
<th>Year 9 if Premium Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 percent</td>
<td>at least 8.5%</td>
<td>at least 11%</td>
<td>at least 13.5%</td>
</tr>
<tr>
<td>50 percent</td>
<td>at least 6.38%, but less than 8.5%</td>
<td>at least 10.38%, but less than 11%</td>
<td>at least 12.08%, but less than 13.5%</td>
</tr>
<tr>
<td>25 percent</td>
<td>at least 4.25%, but less than 6.38%</td>
<td>at least 7.95%, but less than 10.38%</td>
<td>at least 12.25%, but less than 12.88%</td>
</tr>
<tr>
<td>0 percent</td>
<td>less than 4.25%</td>
<td>less than 7.95%</td>
<td>less than 12.25%</td>
</tr>
</tbody>
</table>

(B) Premium performance level.—For purposes of this subsection, the term “premium performance level” means, for a State, market, and year, the percentage reduction in the average per capita premiums for health insurance coverage for the State, market, and year, as compared to the premium baseline for such State, market, and year.

(4) Maximum State premium payment amount.—For purposes of this subsection, the term “maximum State premium payment amount” means, for a State for the small group market or the individual market for a year, the product of—

(A) the percentage (as determined by the Secretary), of the number of nonelderly individuals lawfully residing in all the States who are enrolled in health insurance coverage in the respective market in the year, who are residents of the State; and

(B) the amount available for obligation from amounts appropriated under subsection (d) for such market with respect to performance in such year.

(5) Methodology for calculating average per capita premiums.—
The bonus uninsured percentage for a State is:

<table>
<thead>
<tr>
<th>Bonus Uninsured Percentage</th>
<th>For year 5 if the uninsured performance level of the State is</th>
<th>For year 9 if the uninsured performance level of the State is</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 percent</td>
<td>at least 10%</td>
<td>at least 20%</td>
</tr>
<tr>
<td>50 percent</td>
<td>at least 12.5% but less than 15%</td>
<td>at least 18.75% but less than 20%</td>
</tr>
<tr>
<td>25 percent</td>
<td>at least 13.75% but less than 15%</td>
<td>at least 17.5% but less than 18.75%</td>
</tr>
<tr>
<td>0 percent</td>
<td>less than 5%</td>
<td>less than 12.5%</td>
</tr>
</tbody>
</table>

(B) Uninsured Performance Level.—For purposes of this subsection, the term “uninsured performance level” means, for a State for a year, the reduction (expressed as a percentage) in the percentage of uninsured nonelderly residents for all States in the year, who are residents of such State in the year, as compared to the uninsured baseline for such State for such year.

(4) Maximum State Uninsured Payment Amount Defined.—For purposes of this subsection, the term “maximum State uninsured payment amount” means, for a State for a year, the product of—

(A) the proportion (as determined by the Secretary), of the number of uninsured nonelderly residents in such State in the year, who are residents of such State; and

(B) the amount available for obligation under this subsection from amounts appropriated under subparagraph (d) with respect to performance in such year.

(5) Methodology for Computing the Percentage of Uninsured Nonelderly Residents in a State.—

(A) Establishment.—The Secretary shall establish, by rule and consistent with this subsection, a methodology for computing the average per capita premiums for health insurance coverage for the small group market and for the individual market in each State for each year beginning with year 1.

(B) Adjustments.—Under such methodology, the Secretary shall provide for the following adjustments (in a manner determined appropriate by the Secretary):

(i) Exclusion of Illegal Aliens.—An adjustment so as to not to take into account enrollment of individuals who are not lawfully present in the United States and their premium costs.

(ii) Treating State Premium Subsidies as Premium Costs.—An adjustment so as to increase per capita premiums to remove the impact of premium subsidies made directly by a State to reduce health insurance premiums.

(6) Conditions of Payment.—As a condition of receiving a payment under paragraph (1), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary to determine the State’s premium baseline and uninsured percentage performance level for purposes of this subsection.

(b) Programs That Reduce the Number of Uninsured.

(1) In General.—If the Secretary determines that a State has reduced the percentage of uninsured nonelderly residents in year 5, year 7, or year 9, below the uninsured baseline (as defined in paragraph (2) for the State for the year, the Secretary shall pay the State an amount equal to the product of—

(A) the bonus uninsured percentage (as defined in paragraph (3)) for the State and year; and

(B) the maximum uninsured payment amount (as defined in paragraph (4)) for the State and year.

(2) Uninsured Baseline.—

(A) In General.—For purposes of this subsection, and for purposes of paragraph (1), the term “uninsured baseline” means, for a State, the percentage of nonelderly residents in the State who are uninsured in year 1.

(B) Adjustment.—The Secretary may, at the written request of a State, adjust the uninsured baseline for States for a year to take into account unanticipated and exceptional changes, such as an unanticipated migration, of nonelderly individuals into, or out of, States in a manner that does not reflect substantially the proportion of uninsured nonelderly residents in the States involved in year 1. Any such adjustment shall only be done in a manner that does not result in the allowance of the uninsured baselines for nonelderly residents for all States being changed.

(3) Bonus Uninsured Percentage.—For purposes of this subsection, the term “bonus uninsured percentage” means, for a State for a year, such percentage as determined in accordance with the following table, based on the uninsured performance level (as defined in subparagraph (B)) for such State and year:

<table>
<thead>
<tr>
<th>Bonus Uninsured Percentage</th>
<th>For year 5 if the uninsured performance level of the State is</th>
<th>For year 9 if the uninsured performance level of the State is</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 percent</td>
<td>at least 10%</td>
<td>at least 20%</td>
</tr>
<tr>
<td>50 percent</td>
<td>at least 12.5% but less than 15%</td>
<td>at least 18.75% but less than 20%</td>
</tr>
<tr>
<td>25 percent</td>
<td>at least 13.75% but less than 15%</td>
<td>at least 17.5% but less than 18.75%</td>
</tr>
<tr>
<td>0 percent</td>
<td>less than 5%</td>
<td>less than 12.5%</td>
</tr>
</tbody>
</table>

(4) In General.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(A)—

(I) $18,000,000,000 with respect to performance in year 3; and

(II) $5,000,000,000 with respect to performance in year 6; and

(III) $2,000,000,000 with respect to performance in year 9.

(B) Individual Market.—

(I) In General.—Subject to clause (ii), from any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(B)—

(I) $7,000,000,000 with respect to performance in year 3; and

(II) $2,000,000,000 with respect to performance in year 6; and

(III) $1,000,000,000 with respect to performance in year 9.

(c) Availability of Appropriated Funds.—Funds appropriated under clause (i) shall remain available until expended.

(d) Appropriations; Payments.—

(1) Payments for Reductions in Cost of Health Insurance Coverage.

(A) Small Group Market.—

(i) General.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(A)—

(I) $18,000,000,000 with respect to performance in year 3; and

(II) $5,000,000,000 with respect to performance in year 6; and

(III) $2,000,000,000 with respect to performance in year 9.

(ii) Availability of Appropriated Funds.—Funds appropriated under clause (i) shall remain available until expended.

(B) Individual Market.—

(i) General.—Subject to clause (ii), from any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(B)—

(I) $7,000,000,000 with respect to performance in year 3; and

(II) $2,000,000,000 with respect to performance in year 6; and

(III) $1,000,000,000 with respect to performance in year 9.

(ii) Availability of Appropriated Funds.—Of the funds appropriated under clause (i) that are not expended or obligated by the end of the year following the year for which the funds are appropriated—

(I) 75 percent shall remain available until expended for payments under subsection (a)(1)(B); and

(II) 25 percent shall remain available until expended for payments under subsection (a)(1)(B).

(2) Payments for Reductions in the Percentage of Uninsured.—

(A) In General.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (b)(1)—

(iii) Exclusion of Illegal Aliens.—Such methodology shall exclude individuals who are not lawfully present in the United States.

(v) Conditions of Payment.—As a condition of receiving a payment under paragraph (1), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary in determining the State’s uninsured baseline and uninsured performance level for purposes of this subsection.

(vi) Definitions.—For purposes of this section:

(1) Group Health Plan.—The term “group health plan” has the meaning given such term in section 9832(b)(1) of the Internal Revenue Code of 1986.

(2) Health Insurance Coverage.—The term “health insurance coverage” has the meaning given such term in section 9832(b)(1) of the Internal Revenue Code of 1986.

(3) Individual Market.—Except as the Secretary may otherwise provide in the case of group health plans that have fewer than 2 participants as current employees on the first day of a plan year, the term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(4) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.

(5) Small Group Market.—The term “small group market” means the market for health insurance coverage under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves and (their dependents) through a group health plan maintained by an employee who employed on average at least 2 but not more than 50 employees on business days during a calendar year.

(6) State.—The term “State” means any of the 50 States and the District of Columbia.

(7) Years.—The terms “year 1”, “year 2”, “year 3”, and similar subsequently numbered years mean 2010, 2011, 2012, and subsequent sequentially numbered years.
The plan finder shall meet solvency, financial, and solvency requirements, as determined by each State in which such plan operates:

(A) The health insurance plan shall be acceptable for purposes of this title to the extent required by the State plan finder or in a multi-State plan finder operations, if such licensure is requested by the Secretary.

(B) The health insurance plan may not directly enroll individuals in health insurance plans.

(c) REQUIREMENTS FOR PLAN FINDERS.—

Each plan finder shall meet the following requirements:

(1) D IRECT ENROLLMENT.—The State plan finder or a multi-State plan finder shall assist individuals who are eligible for the Medicaid program under title XIX of the Social Security Act or State Children’s Health Insurance Program under title XXI of such Act by including information on Medicaid options, eligibility, and how to enroll.

(2) REQUIREMENTS FOR PLANS PARTICIPATING IN A PLAN FINDER.—

(a) In general.—Each State shall ensure that health insurance plans offered in the State plan finder or in a multi-State plan finder meet the requirements of paragraph (b) (relating to adequacy of insurance coverage, consumer protection, and financial strength).

(b) SPECIFIC REQUIREMENTS.—In order to participate in a plan finder, a health insurance plan must meet all of the following requirements, as determined by each State in which such plan operates:

(1) The health insurance plan shall be approved by the Secretary, that meets the following requirements:

(i) all financial arrangements involving the sale and implementation of health insurance products, such as the payment of fees and commissions; and

(ii) such arrangements may not be abusive.

(2) The health insurance plan shall maintain electronic health records that comply with the requirements of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) related to electronic health records.

(3) The health insurance plan may not directly enroll individuals in health insurance plans.

(4) The health insurance plan may not directly enroll individuals in health insurance plans.

(c) REQUIREMENTS FOR PLAN FINDERS.—

Each plan finder shall meet the following requirements:

(1) Direct Enrollment.—The State plan finder may not directly enroll individuals in health insurance plans.

(2) Conflicts of Interest.—(A) COMPANIES.—A health insurance issuer offering a health insurance plan through a plan finder may not have an ownership interest in such private entity or in the plan finder.

(B) INDIVIDUALS.—An individual employed by a health insurance issuer offering a health insurance plan through a plan finder may not serve as a director or officer for—

(i) the plan finder or the health insurance plan operator; or

(ii) the plan finder or the health insurance plan operator.

(d) CONSTRUCTION.—Nothing in this section shall be construed to allow the Secretary authority to regulate benefit packages or to prohibit health insurance brokers and agents from—

(1) utilizing the plan finder for any purpose; or

(2) marketing or offering health insurance products.

(e) PLAN FINDER DEFINED.—For purposes of this section, the term ‘plan finder’ means a State plan plan finder under subsection (a) or a multi-State plan finder under subsection (b).

(f) STATE DEFINED.—In this section, the term ‘State’ means a State as defined for purposes of title XIX of the Social Security Act.
"(D) submit to the Secretary a recommendation as to whether the Secretary should adopt such rules.

"(E) IMPLEMENTATION.—

"(1) Optional standard and operating rules. The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules and operating rules that is through a public comment period. The Secretary shall ensure that such rules are effective not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

"(2) Documentation of compliance.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described in paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

"(A) demonstrates to the Secretary that the plan conducts the electronic transactions described in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

"(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

"(3) Submission of certification report.—A health plan shall be required to comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection for any entities that provide services pursuant to a contract with such health plan.

"(4) Certification by outside entity.—

The Secretary may contract with an independent, outside entity to certify that a health plan has complied with the requirements described in paragraph (1), if the entity certifies as being in compliance with such standards and rules. The review committee shall consider and, not less than biennially thereafter, the Secretary shall accept public comments on any interim final rule published under this paragraph (C), (D), and (E), the Secretary shall be subject to a penalty fee that is determined by the Secretary.

"(B) Coordinate of hit standards.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

"(C) Additional penalty for misrepresentation.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) with respect to certification and documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection.

"(D) Annual fee increase.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

"(E) Penalty limit.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis, —

"(i) an amount equal to $20 per covered life under such plan, or

"(ii) an amount equal to $10 per covered life under the plan if such plan has knowledge of the alleged inaccurate or incomplete information (as described under subparagraph (C)).

"(F) Determination of covered individuals.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.
SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION III—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(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 ASSOCIATION HEALTH PLANS"

"SEC. 801. ASSOCIATION HEALTH PLANS.

(a) In General.—For purposes of this part, the term ‘association health plan’ means a 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 subsection (b) if the plan is a sponsor described in this subsection.

(1) eligibility of employees.—The sponsor shall establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Internal Revenue Code of 1986), part C of title XI of the Social Security Act, and regulations promulgated under such Acts.
to an association health plan if the following requirements are met:

(1) each participating employer must be—
   (A) a member of the sponsor, or
   (B) the sponsor, or
   (C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of the 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
   (D) 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 beneficiaries of individuals described in paragraph (a).

[CONGRESSIONAL RECORD — HOUSE November 7, 2009]

H2934

SEC. 805. OTHER REQUIREMENTS RELATING TO ASOCIATION HEALTH PLANS.

(a) COVERED EMPLOYERS AND INDIVIDUALS.—With respect to an association health plan—

(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—
   (A) provides that the board of trustees shall be responsible for selecting a health plan; and
   (B) incorporates the requirements of section 806 in a manner that—
      (i) sets contribution rates based on the claims experience of the plan; or
      (ii) varying contribution rates for small employers

(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS.—If a benefit option does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) MARKETING REQUIREMENTS.—

(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner which is comparable to such use by which such agents are used to distribute health insurance coverage.

(B) STATE LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term "State-licensed insurance agents" means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

(C) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this section shall be prescribed by the applicable authority by regulation.

(5) ABILITY OF ASSOCIATION HEALTH PLANS TO PROVIDE COVERAGE TO INDIVIDUALS NOT EMPLOYED BY AN ASSOCIATION.—The contribution rates for small employers

SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND OTHER MATTERS.

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

(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—
   (A) provides that the board of trustees shall be responsible for selecting a health plan; and
   (B) incorporates the requirements of section 806 in a manner that—
      (i) sets contribution rates based on the claims experience of the plan; or
      (ii) varying contribution rates for small employers

(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS.—If a benefit option does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) MARKETING REQUIREMENTS.—

(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner which is comparable to such use by which such agents are used to distribute health insurance coverage.

(B) STATE LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term "State-licensed insurance agents" means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

(C) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this section shall be prescribed by the applicable authority by regulation.

(5) ABILITY OF ASSOCIATION HEALTH PLANS TO PROVIDE COVERAGE TO INDIVIDUALS NOT EMPLOYED BY AN ASSOCIATION.—The contribution rates for small employers

SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND OTHER MATTERS.

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

(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—
   (A) provides that the board of trustees shall be responsible for selecting a health plan; and
   (B) incorporates the requirements of section 806 in a manner that—
      (i) sets contribution rates based on the claims experience of the plan; or
      (ii) varying contribution rates for small employers

(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS.—If a benefit option does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) MARKETING REQUIREMENTS.—

(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner which is comparable to such use by which such agents are used to distribute health insurance coverage.

(B) STATE LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term "State-licensed insurance agents" means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

(C) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this section shall be prescribed by the applicable authority by regulation.

(5) ABILITY OF ASSOCIATION HEALTH PLANS TO PROVIDE COVERAGE TO INDIVIDUALS NOT EMPLOYED BY AN ASSOCIATION.—The contribution rates for small employers

SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND OTHER MATTERS.

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

(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—
   (A) provides that the board of trustees shall be responsible for selecting a health plan; and
   (B) incorporates the requirements of section 806 in a manner that—
      (i) sets contribution rates based on the claims experience of the plan; or
      (ii) varying contribution rates for small employers

(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS.—If a benefit option does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) MARKETING REQUIREMENTS.—

(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner which is comparable to such use by which such agents are used to distribute health insurance coverage.

(B) STATE LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term "State-licensed insurance agents" means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

(C) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this section shall be prescribed by the applicable authority by regulation.

(5) ABILITY OF ASSOCIATION HEALTH PLANS TO PROVIDE COVERAGE TO INDIVIDUALS NOT EMPLOYED BY AN ASSOCIATION.—The contribution rates for small employers

to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law authorizes an extension of a specific disease from such coverage.

SEC. 806. MAINTENANCE OF RESERVES AND PREMIUMS FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

(a) In General.—The requirements of this section are met with respect to an association health plan if—

(1) the benefits under the plan consist solely of health insurance coverage; or

(2) if the plan provides any additional benefit options which do not consist of health insurance, the plan—

(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting

(i) a reserve sufficient for unearned contributions;

(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

(iii) a reserve sufficient for any other obligations of the plan; and

(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan’s qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(iii) The plan shall secure indemnification insurance for any claims under which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in subsection (a)(2), the applicable authority may prescribe by regulation adjustments in the amount of such insurance as the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 806(a) with respect to any actuarial assumptions, the nature of the plan’s liabilities, and the types of assets available to assure that such liabilities are met.

(b) Additional Requirements.—In the case of any association health plan described in subsection (a)(2), the applicable authority may prescribe additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.

(2) Adjustments for Excess/Stop Loss Insurance.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take account of excess/stop loss insurance provided with respect to such plan or plans.

(c) Alternative Means of Compliance.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute for all or part of the required aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

(1) In General.—In the case of an association health plan described in subsection (a)(2), the applicable authority may prescribe adjustments in the amount of such insurance as the applicable authority determines, taking into account excess/stop loss insurance provided with respect to such plan or plans.

(2) Such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, provided for and maintained reserves in excess of such amount in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(3) Association Health Plan Fund.—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides payment for the first excess/stop loss claims incurred in excess of an amount or amounts specified in such contract, the maximum amount of any payment under such contract being $5,000, and, in addition to such payments, such supplemental payments as the applicable authority may prescribe to be necessary under the circumstances as the applicable authority may prescribe, provided payments under such contract are made in accordance with the requirements of this section;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured.

(4) Measures To Ensure Continued Payment of Benefits by Certain Plans in Distress.—

(1) Payments by Certain Plans to Association Health Plan Fund.—

(A) In General.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of premiums in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the applicable authority may prescribe to be necessary under the circumstances as the applicable authority may prescribe, provided payments under such paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of the plan’s minimum contributions as the applicable authority considers appropriate. The applicable authority may prescribe by regulation minimum standards as the applicable authority considers appropriate.

(B) Which Is Guaranteed Renewable; and

(C) Which Allows for Payment of Premiums by Any Third Party on Behalf of the Insured.

(2) Specific Excess/Stop Loss Insurance.—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides payment for the first excess/stop loss claims incurred in excess of an amount or amounts specified in such contract, the maximum amount of any payment under such contract being $5,000, and, in addition to such payments, such supplemental payments as the applicable authority may prescribe to be necessary under the circumstances as the applicable authority may prescribe, provided payments under such contract are made in accordance with the requirements of this section;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured.

(3) Indemnification Insurance.—For purposes of this section, the term ‘indemnification insurance’ means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides payment for the first excess/stop loss claims incurred in excess of an amount or amounts specified in such contract, the maximum amount of any payment under such contract being $5,000, and, in addition to such payments, such supplemental payments as the applicable authority may prescribe to be necessary under the circumstances as the applicable authority may prescribe, provided payments under such contract are made in accordance with the requirements of this section;
pursuant to section 808(b) (relating to mandatory termination).

(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

(3) which allows for payment of premiums by any third party on behalf of the insured plan.

(1) RESERVES.—For purposes of this section, the term ‘reserves’ means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

(A) a representative of the National Association of Insurance Commissioners;

(B) a representative of the American Academy of Actuaries;

(C) a representative of the State governments, or their interests;

(D) a representative of existing self-insured plans under the applicable authority.

(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

(F) a representative of muliplan types that are or will be located in each such State.

SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

(a) FILING FEES.—Under the procedure prescribed pursuant to section 808(a), an association health plan shall pay to the applicable authority, at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

(b) NOTICE REQUIREMENTS.—No application for an association health plan shall be considered to be located in the State in which it is filed (or at any known address of such individual) unless it is filed with 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 relating to the plan (including any by-laws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and the administrators and other service providers.

(6) FUNDING REPORT.—In the case of association health plans providing benefits options that are themselves prescribed by any applicable authority, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period prior to the date of the application, including the following:

(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement, certified by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period ending on the last day of the plan year.

(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities of the plan as of the 12-month period ended on the last day of the plan year.

(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

(2) developments of anticipated experience under the plan.

The board of trustees of each association health plan shall keep, maintain, and make available such records as necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part.

(3) which allows for payment of premiums by any third party on behalf of the insured plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

(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. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accrual benefit liabilities). The applicable authority of each State 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.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

SEC. 8010. REQUIREMENTS FOR VOLUNTARY TERMINATION.

(1) 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.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

SEC. 8011. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accrual benefit liabilities) the applicable authority of each State 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.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.
applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with the action of the applicable authority (in any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority (in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of such section are remedied or the plan is terminated.

‘'(b) MANDATORY TERMINATION.—In any case in which—

‘‘(1) an applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

‘‘(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any obligation to—

(a) from the applicable authority, in such form and manner as the applicable authority may determine, and, in the event of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or for such purposes as may be necessary in connection with the Secretary’s service as trustee under this section.

**SEC. 811. STATE ASSESSMENT AUTHORITY.**

‘‘(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2009.

‘‘(b) CONTRIBUTION TAX.—For purposes of this section, the term ‘contribution tax’ imposed by a State on an association health plan means any tax imposed by such State if—

‘‘(1) such tax is computed by applying a rate to the amount of premiums or contributions received by insured or uninsured health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan.

‘‘(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insured or uninsured health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan.

‘‘(3) such tax is otherwise nondiscriminatory; and

‘‘(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision by the plan of health care, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

**SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

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

‘‘(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided in section 733(b)(2).

‘‘(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(2).

‘‘(4) HEALTH INSURER.—The term ‘health insurer’ has the meaning provided in section 733(b)(2).

‘‘(5) APPLICABLE AUTHORITY.—The term ‘applicable authority’ means the Secretary, except that, in connection with any exercise of the Secretary’s authority regarding which the Secretary is required to consult with a State, such term means the Secretary, in consultation with such State.

‘‘(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

‘‘(7) INDIVIDUAL MARKET.—
(A) in General.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) Applicability.—Subsection (A) applies to any group health plan that has fewer than 25 employees on the first day of the plan year.

(1) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 25 employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply to an association health plan, if the State in which the plan is located has adopted a rule that is substantially similar to the rule described in section 732(d)(3) on the first day of the plan year.

(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under part 8 with respect to such plan, fund, or program are met, such plan, fund, or program shall be treated for purposes of this part as an employee welfare benefit plan.

(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 provisions of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.”

(2) Section 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 subsection 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(C) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

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

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insular as they may now or hereafter be made, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

“(A) in any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insular as they may now or hereafter be made, or have the effect of precluding, an insurer from offering health insurance coverage of the same policy type under part 8 and the filing, with the State or the sponsor of an association health plan, whether or not such other employers are participating employers in such plan.

“(B) in any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8, the provisions of this title shall supersede any and all laws of such State insular as they may now or hereafter be made, or have the effect of precluding, a health insurance issuer from offering health insurance coverage of the same policy type under part 8 and the filing, with the State or the sponsor of an association health plan, whether or not such other employers are participating employers in such plan.

“(C) The provisions of subsection (d)(1) shall not apply to any State in which an association health plan is offered under a State law in the case of an association health plan which is certified under part 8.”

(c) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following new sentence: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guaranty fund protections to which this Act or applicable State law, if any.”

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

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) Table of contents.—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:

"301. Association health plans.

302. Certification of association health plans.

303. Requirements relating to sponsors and boards of trustees.

304. Participation and coverage requirements.

305. Other requirements relating to plan documents, contribution rates, and benefit options.

306. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

307. Requirements for application and related requirements.

308. Notice requirements for voluntary termination.

309. Corrective actions and mandatory termination.

801. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage; receipt of claims for benefits against the plan.

803. Requirements relating to sponsors and associations.

804. Enforcement provisions relating to association health plans.

(a) CRIMINAL PENALTIES FOR CERTAIN WILFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) in the following new subsection:

"(3) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of the Railway Labor Act (45 U.S.C. 152, as added by the Act), or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

(4) by inserting after clause (iii) the following new subsection:

"(iii) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(1) AGREEMENTS WITH STATES.—The Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which such trust is maintained.

(c) R E S P O N S I B I L I T Y F O R C L A I M S P R O C E D U R E S.—Section 503 of such Act (29 U.S.C. 1133) is amended—

(1) in the following new subsection:

"(4) by inserting after clause (iv) the following new clause:

"(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period.

(2) in clause (iii), by striking "(iii) the determination" and inserting the following:

"(iii)(D) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period.

(3) by redesigning clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

"(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employers of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employ-
(ii) has complete fiscal control over the arrange-
ment and which is responsible for all
operations of the arrangement;
(D) the requirements of section 80(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 satisfies the
requirements in such State on the date of certification.

The provisions of this subsection shall cease to
apply with respect to any such arrange-
ment at such time after the date of the en-
actment of this Act as the applicable re-
quirements of this subsection are not met
with respect to such arrangement.
(2) DEFINITIONS.—For purposes of this sub-
section—
(1) EMPLOYER RETIREMENT INCOME
SECURITY ACT OF 1974.—
(1) GENERAL.—Part 7 of subtitle B of
title I of the Employee Retirement Income
Security Act is amended by inserting
after section 2714 the following new section:

SEC. 715. EXTENDING COVERAGE OF DEPEND-

ENTS.
“(a) IN GENERAL.—In the case of a group
health plan, or health insurance coverage of-
erred in connection with a group health plan,
that treats as a beneficiary under the plan an
individual with respect to any arrangement
that establishes, implements, or continues
operations in any State only if it operates in
any applicable authority with respect to its
arrangement; and
such State on the date of certification.

The provisions of this subsection shall cease to
apply with respect to any such arrange-
ment at such time after the date of the en-
actment of this Act as the applicable re-
quirements of this subsection are not met
with respect to such arrangement.

(2) CLERICAL AMENDMENT.—The table of
sections in such subchapter is amended by
adding at the end the following new item:

Sec. 9814. Extending coverage of depend-
tents through plan year that in-
duces 26th birthday.

(d) EFFECTIVE DATE.—The amendments
made by this section shall apply to group
health plans for plan years beginning more
than 3 months after the date of the enact-
ment of this Act and shall apply to individ-
uals who are dependent children under a
group health plan, or health insurance cov-
erage offered in connection with such a plan,
on or after such date.

SEC. 212. ALLOWING AUTO-ENROLLMENT FOR
EMPLOYER SPONSORED COVERAGE.

(a) IN GENERAL.—No State shall establish a
law that prevents an employer from instit-
sing auto-enrollment for coverage of a par-
ticipant or beneficiary, including current
employees, under a group health plan, or
health insurance coverage offered in connec-
tion with such a plan, so long as the partici-
pant or beneficiary has the option of declin-
ing such coverage.

(b) AUTOENROLLMENT.—
(1) NOTICE REQUIRED.—Employers with
auto-enrollment under a group health plan
or health insurance coverage shall provide
annual notification, within a reasonable pe-
riod before the start of such plan year,
to each employee eligible to participate in the
plan. The notice shall explain the em-
ployee contribution to such plan and the em-
ployee's right to decline coverage.

(2) TREATMENT OF NON-ACTION.—After a rea-
sonable period of time after receipt of the
notice, if an employee fails to make an af-
firmative declaration declining coverage,
then such an employee may be enrolled in
the group health plan or health insurance cov-
erage offered in connection with such a plan.

(c) CONSTRUCTION.—Nothing in this section
shall be construed as requiring a group
health plan to provide benefits for dependent
children as beneficiaries under the plan or
require a participant to elect coverage of de-
pendent children.

(b) PHSA.—Title XXVII of the Public
Health Service Act is amended by inserting
after section 2707 the following new section:

SEC. 708. EXTENDING COVERAGE OF DEPEND-
ents.
“(a) IN GENERAL.—In the case of a group
health plan, or health insurance coverage of-
ered in connection with a group health plan,
that treats as a beneficiary under the plan an
individual who is a dependent child of a
participant or beneficiary under the plan,
the plan or coverage shall continue to treat
the individual as a dependent child without
regard to the individual's age through at
least the end of the plan year in which the
individual turns an age specified in the plan,
but not less than 25 years of age.

(b) CONSTRUCTION.—Nothing in this sec-
tion shall be construed as requiring a group
health plan to provide benefits for dependent
children as beneficiaries under the plan or
require a participant to elect coverage of de-
pendent children.

(2) CLERICAL AMENDMENT.—The table of
sections in each such subchapter is amended by
adding at the end the following new item:

Sec. 9814. Extending coverage of depend-
tents through plan year that in-
duces 26th birthday.

(d) EFFECTIVE DATE.—The amendments
made by this section shall apply to group
health plans for plan years beginning more
than 3 months after the date of the enact-
ment of this Act and shall apply to individ-
uals who are dependent children under a
group health plan, or health insurance cov-
erage offered in connection with such a plan,
on or after such date.

SEC. 212. ALLOWING AUTO-ENROLLMENT FOR
EMPLOYER SPONSORED COVERAGE.

(a) IN GENERAL.—No State shall establish a
law that prevents an employer from instit-
sing auto-enrollment for coverage of a par-
ticipant or beneficiary, including current
employees, under a group health plan, or
health insurance coverage offered in connec-
tion with such a plan, so long as the partici-
pant or beneficiary has the option of declin-
ing such coverage.

(b) AUTOENROLLMENT.—
(1) NOTICE REQUIRED.—Employers with
auto-enrollment under a group health plan
or health insurance coverage shall provide
annual notification, within a reasonable pe-
riod before the start of such plan year,
to each employee eligible to participate in the
plan. The notice shall explain the em-
ployee contribution to such plan and the em-
ployee's right to decline coverage.

(2) TREATMENT OF NON-ACTION.—After a rea-
sonable period of time after receipt of the
notice, if an employee fails to make an af-
firmative declaration declining coverage,
then such an employee may be enrolled in
the group health plan or health insurance cov-
erage offered in connection with such a plan.

(c) CONSTRUCTION.—Nothing in this section
shall be construed as requiring a group
health plan to provide benefits for dependent
children as beneficiaries under the plan or
require a participant to elect coverage of de-
pendent children.

(3) HEALTH INSURANCE ISSUER.—The term
'health insurance issuer' has the meaning
given such term in section 2701(b)(2), except
that such an issuer must be licensed in the
State and be qualified to sell individual
health insurance coverage in that State.

(4) INDIVIDUAL HEALTH INSURANCE
COVERAGE.—The term 'individual health insur-
cance coverage' means health insurance cov-
erage offered in the individual market, as de-
fined in section 2701(e)(1).

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

(b) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably antici-
pated financial condition, a health insur-
ance issuer is likely to be able—
(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or
(B) to pay other obligations in the normal course of business.

(c) COVERED LAWS.—
(A) IN GENERAL.—The term 'covered laws'
means the laws, rules, regulations, agree-
ments, and orders governing the insurance
business pertaining to—
(i) individual health insurance coverage
issued by a health insurance issuer;
(ii) the offer, sale, rating (including med-
ical underwriting), renewal, and issuance of
individual health insurance coverage to an individual; and
(ii) the provision to an individual in rela-
tion to individual health insurance coverage of
health care and insurance related services;
(iv) the provision to an individual in rela-
tion to individual health insurance coverage of
management, operations, and investment
activities of a health insurance issuer; and
(v) the provision to an individual in rela-
tion to individual health insurance coverage of
loss control and claims administration for
a health insurance issuer with respect to li-
ability for which the issuer provides insur-
ance.

(b) EXCEPTION.—Such term does not in-
clude any law, rule, regulation, agreement,
or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, and quality assurance.

‘(8) STATE.—The term ‘state’ means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

‘(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term ‘unfair claims settlement practices’ means only the following practices:

‘(A) Knowingly misrepresenting to claimants or insured individuals relevant fact or policy provisions relating to coverage at issue.

‘(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

‘(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

‘(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in accordance with the terms of an insurance policy or reinsurer.

‘(E) Refusing to pay claims without conducting a reasonable investigation.

‘(F) Failing to affirm or deny coverage of claims with respect to claims arising under policies after having completed an investigation related to those claims.

‘(G) Patterning or practicing of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

‘(H) A pattern or practice of attempting to settle or settling claims for less than the amount of a reasonable person who believes the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

‘(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

‘(J) Failing to provide forms necessary to present claims within 15 calendar days of a request with reasonable explanations regarding their use.

‘(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the state.

‘(10) FRAUD AND ABUSE.—The term ‘fraud and abuse’ means an act or omission committed by a person who, knowingly and with intent, misleads, deceives, or cheats, or submits or causes to be submitted a claim, or submitting, or offering for purposes of receiving service or benefits, or the continuation, renewal, or issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

‘(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the primary State, or

‘(2) require any health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that primary State; or

‘(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

‘(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in an insurance coverage in any secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, and the name of the primary State, respectively, for the coverage concerned:

THIS POLICY IS ISSUED BY AND IS GOVERNED BY THE LAWS AND REGULATIONS OF THE STATE OF , AND IT HONORS ALL THE LAWS OF THAT STATE AS DETERMINED BY THAT STATE’S DEPARTMENT OF INSURANCE. THIS POLICY MAY BE LESS EXPENSIVE THAN OTHERS BECAUSE IT IS NOT SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF THE STATE OF , INCLUDING COVERAGE OF SOME SERVICES OR BENEFITS MANDATED BY THE LAW OF THE STATE OF . ADDITIONALLY, THIS POLICY IS NOT SUBJECT TO ALL OF THE CONSUMER PROTECTION LAWS OR RESTRICTIONS ON RATING FACTORS OF THE STATE OF AS WITH ALL INSURANCE PRODUCTS, BEFORE PURCHASING THIS POLICY, YOU SHOULD CAREFULLY REVIEW THE ISSUER THAT WILL DETERMINE WHAT HEALTH CARE SERVICES THE POLICY COVERS AND WHAT BENEFITS IT PROVIDES, INCLUDING ANY EXCLUSIONS, LIMITATIONS, OR CONDITIONS FOR SUCH SERVICES OR BENEFITS."

‘(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

‘(1) IN GENERAL.—For purposes of this section, a health insurance issuer shall apply to an individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

‘(2) Failing to administer insurance policies on an individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

‘(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the primary State, or

‘(2) require any health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that primary State; or

‘(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

‘(ii) The reinstatement of an insurance policy.

‘(ix) Refusal to pay claims without conducting a reasonable investigation.

‘(G) To comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

‘(H) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks a injunction regarding the violation of this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

‘(2) require any individual health insurance coverage issued by the insurer to be countersigned by an insurance agent or broker residing in that primary State; or

‘(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

‘(I) Failing to pursue or institute suits to recover amounts due under the contract, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

‘(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides health insurance coverage in any secondary State shall apply to an individual health insurance policy or reinsurance contract:

‘(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high-risk premium taxes) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

‘(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

‘(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer’s financial condition, if—

‘(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

‘(ii) any such examination is conducted in accordance with the guidelines of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

‘(D) to comply with a lawful order issued—

‘(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment which would lead a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the insurer is in hazardous financial condition;
“(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

“(B) from raising premium rates for all policyholders within a class based on claims experience;

“(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at the request of the issuer, if such premium changes or incentives—

“(i) are disclosed to the consumer in the insurance contract;

“(ii) are based on specific wellness activities that are not applicable to all individuals; and

“(iii) are not obtainable by all individuals to whom coverage is offered;

“(D) from reinstating lapsed coverage; or

“(E) from retroactively adjusting the rates charged for policies if the initial rates were set based on material misrepresentation by the individual at the time of issue.

“SEC. 2794. PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a primary State unless that coverage is currently offered for sale in the primary State.

“(1) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

“(2) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

“(1) APPLICATION FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

“(i) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or fee schedule in such State unless that coverage is currently offered for sale in the primary State;

“(B) written notice of any change in the designation of its primary State; and

“(C) a qualified loss reserve specialist.

“(ii) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or fee schedule in such State unless that coverage is currently offered for sale in the primary State;

“(B) written notice of any change in the designation of its primary State; and

“(C) a qualified loss reserve specialist.

“(B) QUALIFICATIONS OF INDEPENDENT REVIEW MECHANISMS.—Each health insurance issuer offering coverage in a primary State that does not accommodate residents of secondary States which provides a workable mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in the primary State.

“SEC. 2795. PRIMARY STATE MUST MENT FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

“A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk- based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

“SEC. 2796. ADMINISTRATIVE AND EXTERNAL APPEALS PROCEDURES.

“(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

“(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

“(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the ‘Health Carrier External Review Model Act’ of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer from the issuer and the enrollee (or authorized representative) in the case under review;

“(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a),

“(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

“(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

“(B) with respect to each review, each reviewer meets the requirements of paragraph (4); and

“(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

“(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

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

“(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

“(3) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

“(I) be not be a related party (as defined in paragraph (7));

“(II) not have a material familial, financial, or professional relationship with such a party; and

“(III) not otherwise have a conflict of interest with such a party (as determined under regulations).

“(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

“(I) the individual is not a non-affiliated individual who is not reasonably available;

“(II) the affiliated individual is not involved in the provision of items or services in the case under review;

“(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

“(ii) prohibit an individual who has staff privileges at a hospital where the treatment or care involved took place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

“(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FELD.—

“(a) IN GENERAL.—In a case involving treatment, or the provision of items or services—

“(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the treatment or care involved took place, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty, as a physician who, acting within the appropriate scope of practice...
within the State in which the service is pro-
vided or rendered, typically treats the condi-
tion, makes the diagnosis, or provides the type of treatment under review.

"(B) Plaintiff defined.—For purposes of this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional, that the individual health care service provided to individual patients on average at least 2 days per week.

"(5) Pediatric expertise.—In the case of an expert relating to a child, a re-
viewer shall have expertise under paragraph (2) in pediatrics.

"(6) Limitations on reviewer compensa-
tion.—(A) No compensation shall be paid to an independent medical reviewer in con-
nection with a review under this section shall—
"(i) not exceed a reasonable level; and
"(ii) be contingent on the decision ren-
dered by the reviewer.

"(7) Related party defined.—For pur-
poses of this section, the term ‘related party’ means, with respect to a denial under a coverage relating to an enrollee, any of the following:
"(A) a person that is a related person or fiduciary, officer, director, or employee of the issuer;
"(B) an enrollee (or authorized representa-
tive);
"(C) the health care professional that pro-
vides the items or services involved in the denial;
"(D) the institution at which the items or services (or treatment) involved in the denial are provided;
"(E) the manufacturer of any drug or other item that is included in the items or services of the denial;
"(F) any other party determined under any regulations to have a substantial inter-
est in the denial involved.

"(8) Definitions.—For purposes of this sub-
section:
"(A) Enrollee.—The term ‘enrollee’ means, with respect to health insurance cov-
erage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.
"(B) Health care professional.—The term ‘health care professional’ means an in-
dividual who is licensed, accredited, or cer-
tified under State law to provide specified health care services and who is operating within the scope of such licensure, accredita-
tion, or certification.

"SEC. 2799. ENFORCEMENT.

"(a) IN GENERAL.—Subject to subsection (b), with respect to a specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to en-
force the primary State’s covered laws in the primary State and any secondary State.

"(b) SECONDARY STATE’S AUTHORITY.—

Nothing in subsection (a) shall be construed to limit the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

"(c) NOTICE OF COMPLIANCE FAILURE.—In reviewing action initiated by the applicable secondary State authority, the court of competent ju-
risdiction shall apply the covered laws of the primary State.

"(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance cov-
erage offered in a secondary State that fails to comply with the covered laws of the pri-
mary State, the applicable State authority of the secondary State may notify the applic-
able State authority of the primary State.

"(e) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to pre-
miums for a high deductible health plan for periods beginning after December 31, 2009.

"SEC. 233. REQUIRING GREATER COORDINATION BETWEEN DENTISTS AND HSA ACCOUNT ADMINISTRATORS SO THAT ENROLLEES CAN EN-
ROLL IN BOTH AT THE SAME TIME.

The Secretary of the Treasury, through the issuance of regulations or other guidance, shall encourage administrators of health plans and trusts of health savings accounts to provide for simultaneous enrollment in high deductible health plans and setup of health savings accounts.

"SEC. 234. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ES-
TABLISHMENT OF ACCOUNT.

(a) IN GENERAL.—The amendments made by paragraph (2), an expense shall not fall to be treated as a qualified medical expense solely because such expense was incurred before the enactment of the Act if such expense was incurred during the 60-
day period beginning on the date on which the high deductible health plan is first effec-
tive.

"(b) SPECIAL RULES.—For purposes of sub-
paragraph (A) of this section, an individual shall be treated as an eli-
gible individual for any portion of a month for which the individual is described in sub-
section (c)(1), determined without regard to whether the individual is covered under a high deductible health plan on the 1st day of that month.

"(ii) the effective date of the health sav-
ings account is deemed to be the date on which the high deductible health plan is first effec-
tive after the date of the enactment of the Act.

"(c) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years begin-
ning after such date.

DIVISION C—ENACTING REAL MEDICAL
LIABILITY REFORM

SEC. 301. ENCOURAGING SPEEDY RESOLUTION
OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless after the claimant discovers, or through the use of reasonable diligence should have dis-
covered, the injury, whichever occurs first. In no event shall the time for commence-
ment of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—
(1) upon proof of fraud;
(2) intentional concealment; or
(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s body.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifesta-
tion of injury except that actions by a minor under the age of 6 years shall be commenced within 3 years of manifesta-
tion of injury or prior to the minor’s 8th birthday, whichever provides a longer period.

The time period set forth for mi-
ors for any period during which a parent or guardian and a health care provider or health care organization have concealed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 302. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR AC-
LIABILITY REFORM
in this title shall limit a claimant’s recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of non-economic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) No Discount of Award for Non-Economic Damages.—For purposes of applying the limitation in subsection (b), future non-economic damages shall not be discounted to present value. The jury shall not be instructed to consider a maximum award for non-economic damages. An award for non-economic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future non-economic damages and the combined awards exceed $250,000, the future non-economic damages shall be reduced first.

(d) Recovering Plaintiff’s Contingent Fees in Full.—In any health care lawsuit, each party shall be liable for that party’s share of any damages only and not for any other party’s share of any other party’s damages. Each party shall be liable only for the amount of damages allocated to that party in direct proportion to that party’s percentage of fault. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each party for the amount allocated to that party.

SEC. 305. PUNITIVE DAMAGES.

(a) In General.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure, or that such person deliber- ately failed to avoid unnecessary injury to such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages has been rendered against such per- son, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a separate proceeding—

(1) Evidence relevant only to the claim for punitive damages, as determined by applicable State or Federal law, shall be in any proceeding to determine whether compensatory dangers are to be awarded.

(2) Determining Amount of Punitive Damages.—

(1) Factors Considered.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider the following:

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

(B) The duration of the conduct or any concealment of the conduct;

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

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

(E) Any criminal penalties imposed on such party, 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, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 306. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) In General.—If an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with health insurance or health care insurance provided by any entity, and a periodic payment of such a judgment, the court shall, at the request of any party, either separately or as part of the judgment, authorize the payment of future damages by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(2) ASSIGNABILITY.—See assignment title.

(3) DEFINITIONS.

In this title:

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

(2) CLAIMANT.—The term “claimant” means any person who brings a health care lawsuit, including any 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 benefits; and

(C) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the claimant, or the claimant’s estate, for medical, hospital, dental, or income-disability benefits; and

(D) Any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term “compensatory damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic or personal services, loss of employment, and loss of business or employment opportunities, damages for 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), disability, injury, loss of earning power, and any other nonpecuniary losses of any kind or nature. The term “compensatory damages” includes economic damages and non-economic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term “contingent fee” includes all compensation to any person, whether attorney or otherwise, of a percentage of any recovery that is effectuated on behalf of one or more claimants.

SEC. 307. ECONOMIC DAMAGES.

For purposes of applying the limitation in this title, the term “economic damages” means any 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 or personal services, loss of employment, and loss of business or employment opportunities, damages for 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), disability, injury, loss of earning power, and any other nonpecuniary losses of any kind or nature. The term “economic damages” includes only damages awarded for past injuries or wrongful death, and the term “economic damages” does not include any punitive damages awarded or any other reduction in damages required by law.
(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 services or benefits, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, regardless of whether such lawsuit is brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in anti-trust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or a manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party payers, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term "health care organization" means any person or entity which is obligated to provide or pay for health care services or medical products, for any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

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

(12) MEDICAL LIABILITY.—The term "medical liability" means a liability of any nature to which a Federal rule of law under title XXI of the Public Health Service Act establishes a Federal standard of care, quality improvement, or patient safety.

(13) 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 none pecuniary losses of any kind or nature.

(14) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded, on a conclusive basis and for the sole purpose of punishment, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product. Punitive damages are neither economic nor non-economic.

(15) RECOVERY.—The term "recovery" means the net amount 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. 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.

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

SEC. 308. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) 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 title does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall apply.

(2) 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 title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available to a defendant in a health care lawsuit brought in a Federal or State court or pursuant to an alternative dispute resolution system, pursuant to any provisions of law established by or under this title, notwithstanding section 302(a); or any defense available to a defendant in a health care lawsuit arising from any other law, or any provisions of law that imposes liability, loss, or damages that by this title or otherwise applies to such aspect of such action.

SEC. 309. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title 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 title. The provisions governing health care lawsuits in title XXI may 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 the application of payment of damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or makes any disbursements or costs incurred in connection with a health care lawsuit under any other provision of State or Federal law.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers, health care organizations from liability, loss, or damages than those provided by this title or create greater procedural or substantive protections.

(c) STATE FLEXIBILITY.—No provision of this title shall be construed to preempt—

(1) any State law (whether effective before, or on or after the date of enactment of this Act) that provides greater procedural or substantive protections for health care providers, health care organizations from liability, loss, or damages than those provided by this title or create greater procedural or substantive protections.

SEC. 310. APPLICABILITY; EFFECTIVE DATE.

(1) If any State court, Federal court, or national law applicable in a health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, is inconsistent with this title, notwithstanding section 302(a); or any defense available to a defendant in a health care lawsuit under any other provision of State or Federal law.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 401. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to interfere with the doctor-patient relationship or the practice of medicine.

SEC. 402. RULE OF COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Effective on the date of the enactment of this Act, section 804 of the American Recovery and Reinvestment Act of 2009 is repealed.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

SEC. 501. INCREASED INCOME TAX DEDUCTION AND WELLNESS PROGRAMS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 LIMITATION ON EXCEPTION FOR WELLNESS PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

(1) IN GENERAL.—Section 702(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)(2)) is amended by adding after and below subparagraph (B) the following:

"In applying subparagraph (B), a group health plan (or a group health insurance issuer that provides group insurance coverage (or the group health plan or group health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits to which the variation applies, provided that any such variation in premium or cost-sharing is based on participation in a standards-based wellness program.",

(2) EFFECTIVE DATE.—This subsection shall apply to benefits for plan years beginning after December 31, 2009.
(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO PHSA.—
   (1) GROUP MARKET RULES.—
   (A) In general.—Section 2702(b)(3) of the Public Health Service Act (42 U.S.C. 300gg-9(b)(3)) is amended by adding after and below subparagraph (B) the following:
   
   “In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.”.
   
   (B) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plans years beginning more than 1 year after the date of the enactment of this Act.
   
   (2) INDIVIDUAL MARKET RULES RELATING TO GUARANTEED AVAILABLE ENROLLMENT.—
   
   (A) In general.—Section 274(d) of the Public Health Service Act (42 U.S.C. 300gg-1(b)(2)) is amended by adding after and below paragraph (1) the following:
   
   “In applying paragraph (2), a health insurance issuer with respect to health insurance coverage may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the coverage based on participation in a standards-based wellness program.”.
   
   (B) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to health insurance coverage offered or renewed and after such date of the enactment of this Act.

(c) CONFORMING AMENDMENTS TO IRC.—
   
   (1) In general.—Section 3632(b)(2) of the Internal Revenue Code of 1986 is amended by adding after and below subparagraph (B) the following:
   
   “In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.”.
   
   (2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to health insurance coverage offered or renewed and after such date of the enactment of this Act.

DIVISION F—PROTECTING TAXPAYERS

SEC. 601. PROVIDE FULL FUNDING TO HIS OIG AND HCFA.

(a) HCFAC FINANCING.—Section 1817(k)(3)(A) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is amended—
   
   (1) in clause (i)—
   
   (A) in subclause (IV), by striking “2009, and” and inserting “and 2009”; and
   
   (B) by amending subclause (V) to read as follows:
   
   “(V) for each fiscal year after fiscal year 2009, $300,000,000.”;
   
   and
   
   (2) in clause (ii)—
   
   (A) in subclause (IX), by striking “2009, and” and inserting “2009”;
   
   (B) in subclause (X), by striking “2010” and inserting “2010”;
   
   and
   
   (C) in subclause (XX), by striking “2009” and inserting “2009”.

(b) SUFFICIENCY.—There are authorized to be appropriated for each of fiscal years 2010 through 2012 $100,000,000 for the Office of the Inspector General of the Department of Health and Human Services for fraud prevention activities under the Medicare and Medicaid programs.

SEC. 602. PROHIBITING TAXPAYER FUNDED ABORTIONS AND CONSCIENCE PROTECTIONS.

Title I of the United States Code is amended by adding at the end the following new chapter:

CHAPTER 4—PROHIBITING TAXPAYER FUNDED ABORTIONS AND CONSCIENCE PROTECTIONS

SEC. 301. PROHIBITION ON FUNDRING FOR ABORTIONS.

“Nothing of the funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for any abortion.

SEC. 302. PROHIBITION ON FUNDRING FOR BENEFITS PLANS THAT COVER ABORTION.

“None of the funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for a health benefits plan that includes coverage for abortion.

SEC. 303. TREATMENT OF ABORTIONS RELATED TO RAPE, INCEST, OR PRESERVING THE LIFE OF THE MOTHER.

“The limitations established in sections 301 and 302 shall not apply to an abortion—
   
   (1) if the pregnancy is the result of an act of rape or incest; or
   
   (2) in the case of a woman where a physician, place the woman in danger of death unless abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

SEC. 304. CONSTRUCTION RELATING TO SUPPLEMENTAL COVERAGE.

“Nothing in this chapter shall be construed as prohibiting any individual, entity, or the Secretary to offer, enroll, or increase under any aseparate supplemental abortion plan or coverage that includes abortion as long as such plan or coverage is paid for entirely using only funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for a federally subsidized program, including a State’s or Intragovt contribution of Medicaid matching funds.

SEC. 305. CONSTRUCTION RELATING TO THE USE OF NON-FEDERAL FUNDS FOR HEALTH BENEFITS.

“Nothing in this chapter shall be construed as restricting the ability of any managed care provider or other organization which changes State’s law to provide to a State that violates the ability of a State to contract separately with such a provider or organization for such coverage with funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for a federally subsidized program, including a State’s or locality’s contribution of Medicaid matching funds.

SEC. 306. NO GOVERNMENT DISCRIMINATION AGAINST CERTAIN HEALTH CARE ENTITIES.

“(a) IN GENERAL.—No funds authorized or appropriated by federal law may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institution or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, participate in, or refer for abortions.
   
   (b) HEALTH CARE ENTITY DEFINED.—For purposes of this section, the term ‘health care entity’ includes an individual physician or other private health care provider or an organization, or a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”.

SEC. 603. IMPROVED ENFORCEMENT OF THE MEDICARE AND MEDICAID SECONDARY PAYMENT PROVISIONS.

(a) MEDICARE.—

(1) IN GENERAL.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall provide through the Coordination of Benefits Contractor for the identification of applications which the Secretary determines should be, but is not, acting as a secondary payer to an individual’s private health benefits coverage under section 1862(b) of the Social Security Act (42 U.S.C. 1395m(b)).

(2) UPDATING PROCEDURES.—The Secretary shall update procedures for identifying and resolving credit balance situations which result from the Medicare secondary payer provisions, including recoupment of credit balances.

(b) MEDICAID.—Section 1903 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“RECORD OF MEDICAID PAYMENT.—

“(1) SUBMISSION OF STATE PLAN AMENDMENT.—Each State shall submit, not later than 1 year after the date of the enactment of this Act, a State plan amendment that details how the State will become fully compliant with the requirements of section 1902(a)(25),
   
   (2) BONUS FOR COMPLIANCE.—If a State submits a timely State plan amendment under paragraph (1) that the Secretary determines provides for full compliance of the State with the requirements of section 1902(a)(25), the Secretary shall provide for an additional payment to the State of $1,000,000. If a State certifies, to the Secretary’s satisfaction, that it is already fully compliant with such requirements, such amount shall be increased to $2,000,000.
   
   (3) RECOUPMENT FOR NONCOMPLIANCE.—If a State does not submit such an amendment, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable to this title by 1 percentage point until the State submits such an amendment.
   
   (4) ONGOING REDUCTION.—If at any time the Secretary determines that a State is not in compliance with section 1902(a)(25), regardless of the status of the State’s submission of a State plan amendment under this subsection or previous determinations of noncompliance such certificate, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of noncompliance as determined by the Secretary.”.

SEC. 604. STRENGTHENING MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) PROTECTING AGAINST THE FRAUDULENT USE OF MEDICARE PROVIDER NUMBERS.—Subject to subsection (c),”.

(b) SCREENING NEW PROVIDERS.—As a condition of a provider of services or a supplier, including durable medical equipment supply vendors, home health agencies, applying for the first time for a provider number under the Medicare program and before granting billing privileges under such title, the Secretary shall screen the provider or the supplier for a criminal background or other financial or operational irregularities
through fingerprinting, licensure checks, site-visits, other database checks.

(2) APPLICATION FEES.—The Secretary shall impose an application charge on such a provider or supplier in order to cover the Secretary’s costs in performing the screening required under paragraph (1) and that is revenue neutral to the Federal government.

(3) PROVISONAL.—During the initial, provisional period (specified by the Secretary) in which such a provider or supplier has been issued such a number, the Secretary may implement such safeguard as the Secretary determines to be necessary to assure the entity qualifies for the Medicare program.

(4) PENALTIES FOR FALSE STATEMENTS.—In the case of a provider or supplier that makes a false statement in an application for such a number, the Secretary may exclude the provider or supplier from participation under the Medicare program, or may impose a civil money penalty (in the amount described in section 1128A(a)(1)(A) of such Act).

(5) DISCLOSURE REQUIREMENTS.—With respect to approval of such an application, the Secretary—

(A) shall require applicants to disclose previous affiliation with enrolled entities that have uncollected debt related to the Medicare or Medicaid programs;

(B) may deny approval if the Secretary determines that such affiliations pose undue risk to the Medicare or Medicaid programs, subject to an appeals process for the applicant as determined by the Secretary; and

(C) may implement enhanced safeguards (such as surety bonds).

(b) MORATORIA.—The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud a period of delay for any one applicant cannot exceed 30 days unless cause is shown.

(c) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(2) CONDITION.—The provisions of paragraphs (1) and (2) of subsection (a) shall not apply until the date specified by the Secretary.

SEC. 605. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) GREATER COORDINATION.—The Secretary of Health and Human Services shall provide for increased coordination between the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”) and Federal and State agencies, offices to ensure that providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program are unable to begin operation or participate in the Medicare program in another State.

(b) IMPROVED INFORMATION SYSTEMS.—

(1) IN GENERAL.—The Secretary shall improve information systems to allow greater integration between databases under the Medicare program so that—

(A) Medicare intermediaries, contractors, fiscal intermediaries, and carriers have immediate access to information identifying providers and suppliers excluded from participation in the Medicare and Medicaid programs and other Federal health care programs; and

(B) such information can be shared across Federal health care programs and agencies, including between the Departments of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Defense Department, the Department of Justice, and the Office of Personnel Management.

(c) MEDICARE/MEDICAID “ONE PI” DATABASE.—The Secretary shall implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.

(d) AUTHORIZING EXPANDED DATA MATCHING.—Notwithstanding any provision of the Computer Matching and Privacy Protection Act of 1988 to the contrary—

(1) the Secretary and the Inspector General in the Department and Human Services may perform data matching of data from the Medicare program with data from the Medicaid program; and

(2) the Commissioner of Social Security and the Secretary may perform data matching of data from the Social Security Administration with data from the Medicare and Medicaid programs.

(e) CONSOLIDATION OF DATA BASES.—The Secretary shall consolidate and expand into a centralized database for individuals and entities that have been excluded from Federal health care programs and agencies, subject to an appeals process for the applicant as determined by the Secretary; and

(f) COMPREHENSIVE PROVIDER DATABASE.—

(1) ESTABLISHMENT.—The Secretary shall establish a comprehensive database that includes information on providers of services, suppliers, and related entities participating in the Medicare program, the Medicaid program, or both. Such database shall include information on ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any provider or supplier.

(2) USE.—Prior to issuing a provider or supplier number for an entity under the Medicare program, the Secretary shall obtain information on the entity from such database to assure that the entity qualifies for the issuance of such a number.

(g) COMPREHENSIVE SANCTION DATABASE.—

The Secretary shall establish a comprehensive sanctions database on sanctions imposed on providers of services, suppliers, and related entities. Such database shall be overseen by the Inspector General of the Department of Health and Human Services and shall be linked to related databases maintained by State licensure boards and by Federal or State law enforcement agencies.

(h) ACCESS TO CLAIMS AND PAYMENT DATABASES.—The Secretary shall ensure that the Inspector General of the Department of Health and Human Services and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

(i) CIVIL MONEY PENALTIES FOR SUBMISSION OF ERRONEOUS INFORMATION.—In the case of a provider of services, supplier, or other entity that submits an application that serves as a basis for payment of any entity under the Medicare or Medicaid program, the Secretary may impose a civil money penalty of not to exceed $50,000 for each erroneous submission. A civil money penalty under this subsection shall be imposed and collected in the same manner as a civil money penalty under section 1128A of the Social Security Act is imposed and collected under that section.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

SEC. 701. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting “under this subsection (k)” after “biologics license”; and

(2) by adding at the end the following:

(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

(2) CONTENT.—

(A) IN GENERAL.—

(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

(II) the biological product is biosimilar to a reference product based upon data derived from—

(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

(bb) animal studies (including the assessment of toxicity); and

(cc) nonclinical studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed, but only to the extent the mechanism or mechanisms of action are known for the reference product;

(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

(V) the facility in which the biological product is manufactured, processed, packaged, or held meets standards designed to ensure that the biological product continues to be safe, pure, and potent.

(ii) ADDITIONAL REQUIREMENTS.—An application submitted under this subsection—

(I) shall include publicly available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (a)(1)(K)(ii).

(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an
application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

(i) is biosimilar to the reference product; or

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

(4) STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

(A) the biological product—

(i) is biosimilar to the reference product; and

(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

(B) the product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

(5) TEMPORARY LICENSES.

(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be licensed against more than 1 reference product.

(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

(C) NOTIFICATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies for the Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under section 121.4 of title 9, Code of Federal Regulations.

(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 3808 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

(E) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability under section 506A(d)(3) of the Federal Food, Drug, and Cosmetic Act, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use for which—

(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product; or

(B) 18 months after—

(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(C) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

(iii) 18 months after approval of the first interchangeable biosimilar biological product if the Secretary determines, after consultation with the Secretary shows that a biological product—

(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) a subsequent application filed by the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

(5) EXCLUSIVITY FOR REFERENCE PRODUCT.—

(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION.—If an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary after the date on which the application has not been sued under subsection (l)(5) for a period of 4 years after the date on which the reference product was first licensed under subsection (a).

(C) FIRST LICENSE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

(i) a supplement for the biological product that is the reference product; or

(ii) a supplement filed by the same sponsor or manufacturer of the biological product that is the reference product (or a successor, predecessor in interest, or other related entity for—

(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosage form, delivery system, delivery device, or strength; or

(II) a modification in the structure of the biological product that does not result in a change in safety, purity, or potency.

(D) PEDIATRIC STUDIES.—

(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population is needed and that the Secretary will use to determine whether a biological product is biosimilar to the reference product in such a manner as such provisions apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under section (b) or (c) of section 506A of the Federal Food, Drug, and Cosmetic Act.

(B) GUIDANCE DOCUMENTS.—

(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(b) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

(iv) PUBLIC COMMENT.—

(A) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subsection (a) before issuance.

(iii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide input regarding priorities for issuing guidance.

(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

(i) the criteria that the Secretary will use to determine whether a product is highly similar to a reference product in such product class; and

(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

(E) CERTAIN PRODUCT CLASSES.—

(A) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this section for such product or product class.

(B) MODIFICATION OR REVERSAL.—The Secretary may issue a summary guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

(C) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

November 7, 2009
biosimilar product; and

(iii) If the reference product sponsor provides the list required by clause (i) to the applicant, the reference product sponsor shall identify that patent to the applicant and issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information, or the party providing the information pursuant to clause (ii), the applicant and interested third party otherwise agree.

(ii) Within 90 days of the date of receiving the information pursuant to clause (i), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns or has rights under 1 or more patents that may be relevant patents. The list shall include the information specified in subparagraph (B), and shall be identified, unless the interested third party otherwise agrees.

(iii) Within 90 days of the date of receiving the information pursuant to clause (i), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns or has rights under 1 or more patents that may be relevant patents. The list shall include the information specified in subparagraph (B), and shall be identified, unless the interested third party otherwise agrees.

(iv) If the interested third party issues or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

(C) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use such information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

(D) EXCHANGES WITH INTERESTED THIRD PARTIES.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

(A) the reference product identified in the application; and

(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

(E) AGREEMENTS.—

(A) REQUIREMENTS.—

(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B) for agreements described in paragraph (4)(A), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT SPONSOR AND REFERENCE PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products that are the same product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, sale, distribution, or importation into the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product in the United States, of an application, which would not infringe the patent; or

(ii) the patent is invalid or unenforceable.

(C) FILING.—

(i) IN GENERAL.—The text of an agreement described in subparagraph (A)(i) or (ii) of paragraph (4)(A) shall be filed with the Assistant Attorney General of the United States and the Federal Trade Commission not later than

(ii) 30 days after the date on which the agreement is executed; and

(iii) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(ii), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(i), any biosimilar product that is the
subject of an application described in such subparagraph.

"(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms of the agreement.

"(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed shall each file written descriptions of the agreement that are sufficient to disclose all the terms of the agreement.

(b) Definitions.—Section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) is amended—

(1) by striking "in this section, the term 'biological product' means" and inserting the following:

"(1) The term 'biological product' means;"

(2) in paragraph (1), as so designated, by inserting "protein (except any chemically synthesized polypeptide)," after "allergenic product," and

(3) by adding at the end the following:

"(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

(3) The term 'interchangeable' or 'interchangeability' with respect to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

(4) The term 'reference product' means the single licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).

(c) Products Previously Approved Under Section 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 505 of the Public Health Service Act (42 U.S.C. 262) as amended by this Act.

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this section as 'the Secretary') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(d) Deemed Approved Under Section 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(e) Definitions.—For purposes of this subsection, the term "biological product" has the meaning given such term in section 351(l)(4)(D) of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) Fees Relating to Biosimilar Biological Products.—Subparagraph (B) of section 735(l) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379f(l)) is amended by inserting "; including licensure of a biological product under section 351(k) of such Act' before the period at the end.
individuals or small businesses to group together for the purposes of buying health insurance like big businesses and unions can today. How about getting rid of junk lawsuits that drive up the cost of health care in America and the defensive medicine that doctors have to practice as a result.

I think what we have before us and the bill that we are offering is a commonsense approach that does take major steps in the right direction to bring down the cost of health care and to expand access.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I seek to control the time in opposition, and I ask unanimous consent that the time for opposition speakers on the substitute amendment be divided such that the first 10 minutes is controlled by Chairman MILLER of the Committee on Education and Labor; the second 10 minutes is controlled by Chairman RANGEL of the Committee on Ways and Means; and the final 10 minutes is controlled by Chairman WAXMAN of the Committee on Energy and Commerce.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) is recognized to control the time in opposition.

Without objection, that time will be divided, subject to the Chair’s discretion as to the order of recognition.

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, I am here to speak in support of the Affordable Health Care for America Act, one of the most important pieces of legislation this body has considered since the passage of Medicare in 1965 and Social Security in 1935.

Mr. Speaker, every Member of this body has been listening to her or his constituents, and they are saying that they are ready for health insurance reform. They need health insurance reform.

We listened when seniors said they wanted better care from their doctors, and the doughnut hole eliminated. This bill does that. When we listened when young adults told us they were having trouble finding care and wanted to stay on their parents’ insurance until age 27. This bill does that. We listened when the uninsured told us heart-breaking stories about going without needed health care and asked us to give them affordable, quality health care insurance. This bill does that. We listened when the insured told us they were paying too much for insurance and they needed more protections for their health insurance. This bill does that.

Our colleagues on the other side of the aisle have not listened. They are offering a substitute bill that would not accomplish any of the things our constituents have asked for. Instead, they are offering a bill that does not end the discrimination based on preexisting conditions; does not reduce the number of uninsured Americans; does not offer assistance to those struggling to afford health insurance; does not stop price gouging for health insurers; and does not stop price gouging by insurance companies. Our bill does all these things and more.

Mr. Speaker, the Affordable Health Care for America Act not only brings quality health care within reach of tens of millions of Americans, it enhances the care that those with insurance and Medicare already receive. This bill is as much about the insured as it is about the uninsured. It is a monumental bill. I urge defeat of the Republican substitute and, indeed, encourage passage of H.R. 3962.

The SPEAKER pro tempore. Without objection, the gentleman from Michigan will control the time on the proponent’s side.

There was no objection.

Mr. CAMP. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the American people deserve and demand a commonsense approach to health care reform that, one, makes health care more affordable; two, that guarantees all Americans, regardless of preexisting condition, have access to affordable health care; and, three, does so without raising taxes, without the Federal Government making health care decisions that should be made by patients and doctors.

The Common Sense Health Care Reform and Affordability Act, the House Republican health care bill, does that. The plan offered today by the Speaker does not.

Just some of the highlights of the Republicans’ Common Sense Health Care Reform and Affordability Act include:

- Lowering health care premiums: The Republican plan will lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.
- According to the Congressional Budget Office, the Republican health care reforms would reduce premiums by up to 3 percent for Americans who get insurance through their employers, up to 8 percent for Americans without employer-sponsored insurance, and up to 10 percent for those working for a small business. CBO has not made a claim that the Democrats’ bill would lower premiums at all.

What do these numbers mean? It means families who do not have health insurance in 2016 through their job could buy health insurance that is $5,000 less expensive than the cheapest plan the Republicans’ substitute will offer.

The Republican plan guarantees access to affordable health care for those with preexisting conditions. Republicans create universal access programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of preexisting conditions or past illnesses, have access to affordable care, while lowering costs for all Americans.

The Republican plan includes the number of junk lawsuits, which saves taxpayers’ money and lowers premiums, by enacting medical liability reforms modeled after the successful State laws of California and Texas.

The Republican plan guarantees Small Business Health Plans so these employers can pool together and offer health care at lower prices, just as large corporations and labor unions do today.

The Republican plan encourages innovative programs by rewarding States that reduce premiums and the number of uninsured. In comparison, the Demo- crats’ number-one priority for health care reform is not what the American people want. Americans are clamoring for affordable care, and that is what the Republican plan offers.

I urge my colleagues to reject the Democrats’ government takeover of health care and vote “yes” on the Republican substitute that will lower health care premiums.

I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members not to traffic the well when another Member is under recognition.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2½ minutes to the gentleman from Massachusetts (Mr. TIERNEN), a member of the committee.
Mr. TIERNEY. I thank the gentleman.

Since 1995, when our Republican colleagues held the majority in the House of Representatives, until 2007 when they relinquished that and the voters threw them out, they had done exactly nothing, nothing, with respect to the health care crisis in this country.

Now they want to come in and they want to do something. They want to have in you less for getting less. This is their great plan.

The one thing they tried to do in 2003 would put pharmaceutical prescription drugs in Medicare which they did by giving seniors a so-called doughnut hole they had to pay for and costing us $900 billion on our current debt.

My friends, the only ones they made happy then were the pharmaceutical companies, and the only ones they want to make happy now are the private insurance companies. They want to try to kill reform. If they can’t kill reform, they want to give them this gift of a Republican substitute.

While they sat idle since 1995, family health policies rose from 7 percent of median income to 17 percent. Sixty percent of families reporting bankruptcies did so in part because of health care costs. Forty-six million Americans went uninsured, 85 percent of those in working families.

Small business premiums went up 129 percent. Twenty-eight million of our uninsured are small business owners, employees or their families. Small businesses are projected to lose $52.1 billion in the next decade if we continue on the Republican path of do nothing.

The question is, who is on our side? Who is on the side of the consumers, the individuals, the small businesses and the families, and that is the bill that the Democrats have put forward on this floor. It is affordable; it is health care for every American.

If you compare the two bills, you will see the Congressional Budget Office says the Republicans may—may—save you from 0 to 3 percent on 80 percent of the private premiums.

The Democratic bill saves you 12 percent. The Democratic bill covers 96 percent of Americans. The Republicans in 2019 will leave you exactly where you are today, covering only 83 percent of the people, leaving by that time 52 million uninsured.

We will end the discrimination against people with preexisting conditions. They will study it.

We will have an exchange for small businesses and employees so they get better prices comparable to what large companies get and become able to get. They will do nothing of the kind except let you shop for a place, but to get your insurance it might cost you less because you get less, because you will have a race to the bottom, where insurance companies will be able to avoid consumers of State governments of State insurance practice fraud almost indiscriminately. There will be no way of cutting it back. You pay less because you get less.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

When Republicans were in the majority, we passed a children’s health initiative; a prescription drug plan for seniors; we put wellness into Medicare; we established portability so people could change employers and keep their health care; and we established health savings accounts. Our record on health care is strong. What we need is this continuation of this step-by-step approach to comprehensive health care reform.

I would now yield 5 minutes to the distinguished gentleman from Indiana (Mr. PENCE).

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

Mr. PENCE. Mr. Speaker, I rise in support of the Republican substitute.

After months of overwhelming public opposition to a government takeover of health care, liberal Democrats here in Washington ignored the clear voice of the American people, bringing forth a freight train of runaway Federal spending, bloated bureaucracy, mandates and higher taxes.

And even a few courageous Democrats had the courage to speak out. In opposing the bill, the distinguished Democrat chairman of the Armed Services Committee, IKE SKELETON, said that he, quote, had serious concerns for Missourians who have private insurance plans they like.

And my Democrat colleague, DAN BOREN of Oklahoma, said, and I quote, the worst thing we could do in a recession is raise taxes, and this bill does just that.

□ 2030

As these Democrat colleagues attest, if the Pelosi health care bill passes today, you will probably will lose your health insurance, and you might just lose your job. The Pelosi health care plan targets us when we are most vulnerable. Illness, our own, or, more importantly, the illness of a parent, spouse or a child, has the capacity to exceed our priorities. What was important before the crisis grows dim in the harsh light of disease affecting a loved one. The result, little by little, in the midst of a family crisis we yield our freedoms and our resources to the ever-growing appetite of the Federal Government.

But if liberal Democrats think this is what our Nation wants, they don’t know the America that I know.

Mike Schwaller is my cousin. He is an extraordinary young man. He has been struggling with cancer, but throughout has maintained his faith in Christ and his courage. He has been an inspiration to us all.

Mike wrote me an email the other day, and he gave me permission to share it. He is awaiting insurance approval for experimental treatment. He seems like just the kind of American that my Democrat colleagues keep telling us want government-run insurance. But they don’t know Mike.

As he wrote about his coverage recently, he said, If this was a government-run health care system, I know the faith that it would be processed in a timely manner, and even then, if it would be approved. The idea of a public health care option, he wrote, as a chronic cancer patient scares the living hell out of me. I feel that at this moment in time you are betting for your life. Please, please, don’t give up or give in. Michael, we won’t.

The truth is, this debate is not just about health care. It is about who we are as a nation. As President Reagan said, it is about whether we abandon the American revolution and confess that a little intellectual elite in a far distant capital can plan our lives better for us than we can plan them for ourselves.

You know, earlier today I greeted about 50 Hoosiers, mostly in wheelchairs, unit caps and uniforms, down at the World War II Memorial. These heroes were gathered for their first and maybe their only visit to that monument built in their behalf.

As I made my way back to the Capitol, I thought about those brave men and what sustained them in those days where the survival of democracy hung in the balance. I believe it must have been because they were fighting for a cause more important than their health or even their lives, and that cause was freedom.

In the coming hours, we are going to take a vote of incalculable significance to the American people, and we will see what our so-called Blue Dog Democrat colleagues are made of. We will see whether Democrats who profess to believe in limited government will take a stand, or whether they will fold under the weight of the Democratic majority in the White House.

Look. I know from personal experience, it is no easy thing to take on your President or your party on a major piece of legislation. But let me assure my colleagues, decent Americans all, if you will take this stand for freedom, for the right to live and work and care for a family without the unnecessary intrusion of the government, I believe with all my heart that you will know for the rest of your lives just what those men in wheelchairs have known every day since they came home, that when freedom hung in the balance, you did freedom’s work, and the American people will never forget it.

Mr. GEORGE MILLER of California. I yield 1½ minutes to the gentleman from Virginia (Mr. SCOTT), a member of the committee.

(Mr. SCOTT of Virginia asked and was given permission to revise and extend his remarks.)

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the freedom to be uninsured. Seniors in my
Mr. MCCAOTTER. I thank the gentleman. The substitute should be defeated.

Mr. CAMP. At this time I yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the ranking member of the Energy and Commerce Committee.

Mr. BARTON of Texas. Mr. Speaker, if the Republicans' substitute responds to the comprehensive Affordable Healthcare for America Act with a bill that fails to reduce costs, fails to cover uninsured Americans, and it may study, but it does not help, those with preexisting conditions. It does not help, however, attack innocent victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs, and yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of malpractice. For those victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts total medical malpractice from the doctor to the victim’s own private insurance, and, in some cases, causes the injured victims to lose the right to sue before they even know they have been injured.

None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now.

The Republicans should leave the insurance industry alone and focus on the real problem: the rising costs of medical malpractice. And the substitute handles this problem in an administrative way.

In essence, the substitute bill would create an administrative board to try and limit payments to malpractice victims. It would give the Department of Health and Human Services broad discretion to decide on a case-by-case basis how much money would be paid to malpractice victims.

I yield myself 2 minutes.

Mr. GEORGE MILLER of California. I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS), a member of the committee.

Mr. ANDREWS. Mr. Speaker, when you can’t win on the facts, you resort to emotion. The majority can’t win the argument with insured people because they preserve the right of insurance companies to discriminate on the basis of preexisting conditions.

They can’t win the argument with senior citizens because they ignore the doughnut hole that they created in 2003 in the Medicare part D.

And they don’t ignore the uninsured. I will give you an example of that. There are going to be 50 million uninsured in 2010. They do change that. Their plan would make it 55 million uninsured 10 years from now.

So they are standing on a motion, and we hear a Member say this: ‘‘We cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer.’’

But there was a current Member, and the time wasn’t now, and the issue wasn’t this bill. The Member was Durward Hall, the time was 1965, and the issue was Medicare.

They were wrong then, they are wrong now, and their substitute is wrong. You should vote no.

Mr. GEORGE MILLER of California. I yield myself 2 minutes.

Mr. Speaker, if the Republicans’ health care plan was a plan for a fire department, they would rush into a burning building, and they would rush out and leave everybody behind. If their plan was an evacuation plan, it would be like Katrina. When they got all done evacuating people, they left them all behind.

They say their plan is inexpensive. They say their plan saves somebody money. But 10 years from now there will as many uninsured as there are now.

At the end of their watch, after 12 years of control of this Congress, 8 years of control of the White House at the same time, the Republicans have succeeded in making 50 million Americans without health insurance.

That is what they left behind on their watch. Now they come forth with a plan for the future, and over the next decade they are going to leave behind 50 million Americans.

Want to buy it? Want to try it? Want to sell it? Come on, America. Buy this one. You are guaranteed to be left behind if you are left behind today.


Mr. CAMP. At this time I yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the ranking member of the Energy and Commerce Committee.

Mr. BARTON of Texas. Mr. Speaker, I asked to go after the distinguished chairman of the Education and Labor Committee because what we have here is a failure to communicate, or perhaps a difference in philosophy.

The Democrats have decided that the bottom line is coverage. By golly, coverage matters. If you want to be covered or not, you are going to be. We are going to have an employer mandate. We are going to have an employee mandate and an individual mandate. We are going to have a premium mandate.

We are going to have how you cover the insurance, a “comparative research council,” to dictate the practice of medicine. We are going to raise Medicaid to 150 percent of poverty, and add that on the belly of the individual in this country who is unmarried, whether they want to be or not.

We are going to tell every young American who has decided that they don’t want to pay those premiums, they want to save up to get married or to buy a home, that, by golly, they are going to have to take insurance, and they are going to pay three to four times what they would under the current system because there is only a two-to-one ratio. So they are going to get their coverage, at a cost of $1.2 trillion.

Now, we have a different philosophy. We think you need to control costs, but we also agree that you have to provide access to the private insurance market if you can’t get it today and you want it.

Congressman MILLER talks about the 40 to 50 million Americans that are not insured, and he is right. But of those 40 to 50 million, 10 to 20 million are in this country illegally. Ten or 15 million are young Americans who don’t want insurance.
When you really boil it down, there are 5 to 10 million Americans who have a preexisting condition or work where insurance is not provided and they can't afford it.

Our plan covers them. It gives them the opportunity. That doesn't give them the money, but it gives them the opportunity. So we have a difference in philosophy.

We don't believe in mandates and make no apology about it, but we do believe in the individual opportunity. We believe in individual choice. We believe in the American system of free enterprise. We believe in lower taxes, and we believe in a plan that's going to lower premiums an average of $5,000 per person per year for the next 10 years. That's what CBO says. That's not me. That's the CBO.

So there is a choice. Bigger government, more mandates, more control, less freedom, or lower costs, more opportunity, more freedom, more choice. I vote for more freedom.

Vote "no" on the Big Government plan. Vote "yes" on the individual opportunity plan.

Mr. RANGEL. At this time, I yield 1 minute to the gentleman from California (Mr. STARK), the chairman of the Ways and Means Subcommittee on Health.

I would like to take this time to thank him for the great work he's done over the years, not just for our committee, but for this Congress, and I would like to thank him publicly.

Mr. STARK. I thank the chairman for yielding.

Mr. Speaker, the Republican substitute is not a substitute on health reform. It substitutes gifts to the wealthy insurance companies for morality and dignity. Their bill spends $61 billion over the next decade, and what would the American public get for that investment? It would get 5 million more uninsured people than we have in America today. That's not a conservative solution. It's no solution at all.

Our legislation expands coverage to 36 million more Americans, reforms the insurance market to end abusive practices, provides financial assistance to lower-income and middle-income families, creates a public health insurance option that will make health insurance more affordable, and protects seniors' futures by not adding one dime to the deficit.

A vote for the Republican substitute is nothing more than a vote for transferring money to wealthy insurance companies. Vote "no" on the Republican substitute and "yes" to provide affordable, quality health care for all Americans.

Mr. CAMP. At this time, I yield 1 minute to the gentleman from South Carolina (Mr. BROWN).

Mr. BROWN of South Carolina. Mr. Speaker, I rise in strong support of the Republican amendment and true health care reform. Our plan makes the cost-saving changes so sorely needed in our health care system without forcing our children and grandchildren into onerous debt.

This amendment will allow insurance to be bought at these prices. People can hire the business to drive down costs and allow small businesses to band together in order to negotiate fair and affordable coverage. Furthermore, this amendment improves quality, putting you and your doctor in charge of your care by removing the powers of insurance companies and trial lawyers.

Finally, this amendment ensures that the taxpayer dollars my constituents in South Carolina's First Congressional District pay into the Federal Treasury never find their way into abortion clinics.

Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote "no" on the House passage.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington, Dr. McDermott, who worked his whole career down here to improve the quality of health care for all Americans.

Dr. McDermott asked and was given permission to revise and extend his remarks.

Mr. McDermott. Mr. Speaker, the Republican health plan and proposal has been in effect since 1995. A friend of mine went to New York, had some problems, got on the phone to call a doctor, and the first question that is always asked is what kind of insurance do you have. When he said he didn't have any, they said, Well, we can't take care of you unless you come to the office with $250 in cash. We'll see you if you do that. He said, I don't have that kind of money. They said, Then go to the emergency room. That's where 50 million people in this country are today. Get to the emergency room if you can't come with the cash to hand it to the doctor.

My phone office today has been ringing off the hook with people demanding that we have health care now. The Republican alternative doesn't help anyone, except protects the insurance companies. The bankruptcy of this plan is pretty clear to everybody. Health analysts, the media, The New York Times, the CBO all agree that the Republican plan would leave 42 million out in the cold. The Republican plan does nothing to help people with pre-existing conditions or to help seniors. The Republican plan is no plan.

How could they have put forward a plan that doesn't solve any of the healthcare problems Americans face? Well, I may have cracked the code. Either they haven't read their own bill or they'd rather spend more time hating government than helping people.

The Republican approach is just a continuation of the status quo while the Democratic plan covers 96% of Americans. My constituents have demanded action. The time is now. Mr. RANGEL. No one has worked harder on this bill than Congressman Lloyd Doggett from Texas, and it's my honor to now yield 2 minutes to the gentleman.

Mr. DOGGITT. To help cover huge medical bills in Bastrop, Texas, they held a Main Street pancake supper, an auction at the American Legion. Well, essential health care shouldn't depend on the kindness of strangers or the good faith of neighbors and certainly not on the "just say no" of the Republican Party or the weak TEA parties brewed up by the insurance lobby.

Now, belatedly, they offer a scheme as skimpy as a hospital gown. They do nothing to help the people. Their proposal is inefficient, it's ineffective, and it's wasteful. Masquerading as reform, their bill authorizes insurers to continue denying coverage for preexisting health conditions, such as acne or a C-section. Republican obstructionism has itself become one giant preexisting condition to meaningful change.

This is a typical old-time Republican medicine show. Do a little bit for 5 percent of the people. Do nothing for the other 95 percent of the uninsured, and leave the portion of American families who are uninsured the same tomorrow as today. The only thing they propose more of is more insurance policy loopholes.

Freedom. They want the freedom to go broke after a medical emergency, the freedom to have more bankruptcies, medical bills—the number one cause of personal bankruptcy in America today. We cannot create bi-partisan support for insurance reform tonight because they don't support any real solutions for the uninsured.
Our Democratic plan is a lifesaver for 12 times as many Americans, and it’s a dollar saver, responsibly reducing the national debt by $36 billion more than this phony Republican scheme.

Now is the time for a truly historic choice. The Republicans have chosen to side against insurance monopolies. We choose to strengthen Medicare. We chose to stand up for the millions of struggling families who have been denied health care access for too long.

Mr. RANGEL. Could I ask how much time I have remaining, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from New York has 5 minutes remaining.

Mr. RANGEL. I yield 2 minutes of that time to the gentleman from Oregon (Mr. BLUMENAUER) and ask him to share the great contribution he has made and the loopholes we find in the Republican substitute.

Mr. BLUMENAUER. I appreciate the gentleman’s courtesy.

I hope every American examines the plan that has been offered to us by the Republicans.

Our citizens are outraged by practices of taking away insurance when you buy your own plans, curtailing coverage for preexisting conditions. Our bill fixes it. You won’t find it in the Republican bill. Republicans strip out provisions so important to Oregon and other low-cost, high-quality States. Republicans do not deal with those vast regional disparities.

They ignore the extra costs faced by seniors caught in the prescription drug doughnut hole while Democrats provide financial relief within the next 2 months. If Republicans have their way, there will be more uninsured Americans in 10 years than there are today. Weaker protections ignore the needs of the most vulnerable, yet the CBO says the Republican plan will increase the deficit by $36 billion more than the Democratic plan.

Mr. Speaker, this is a colossal failure of imagination. The Republicans could have passed this package any time during the 6 years they and George Bush ran everything. They didn’t bother because it wasn’t worth it.

Last March, Republican Minority Leader BOEHNER famously said that his Members shouldn’t legislate. With this package as the best they could do, the Republicans have met the challenge not to legislate.

Mr. CAMP. Mr. Speaker, at this time, I yield 3 minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Speaker, I thank the gentleman for yielding.

The Republican Congress did send important parts of this plan, the House, to the other body. We sent lawsuit abuse reform seven times. We sent associated health plans at least a half dozen by $36 billion. They didn’t get to the floor. We continue to send the elements of this plan that save every taxpayer money and also save every insured American money. This is the only plan that reduces the cost of insurance for every group of insured Americans.

One of the goals that the President set for health care reform was to reduce the cost of premiums. This is the only plan that does that. It does it for individuals. It does it for small businesses. It does it for large groups.

This is a plan where we could provide access to coverage for everyone regardless of preexisting conditions. Now, we don’t spend $1.3 trillion to do that. We spend about $23 billion to make the risk pool large enough for everybody to have access for everybody. We’re for access for everybody to coverage; we’re just not for spending $1 trillion to create that access.

This plan lowers premiums. It prohibits insurance companies from canceling policies. It prohibits insurance companies from capping the lifetime expenditures that those policies might incur.

One of the reasons that there were more people uninsured at the end of the 10 years under this plan is, when our friends on the other side insisted on the children’s health insurance plan, they put everybody that goes on that plan in the first 5 years back into no insurance in the last 5 years. Look at the numbers. That’s where those numbers go up. You could pretend that our plan puts the numbers up. We’re not the one that said we’re going to insure all children for 5 years and in the second 5 years they’re back where they are today. Check the numbers. Look at what this does for premiums. Look at what this does for families.

This plan is a plan that truly does keep what works and fixes what’s broken. The President repeatedly has said, Everyone, if you like what you have, you should be able to keep it. This is the only plan that would allow that pledge to be made and be kept.

Mr. Speaker, I encourage my colleagues to support this plan. Let’s take these first steps that work without bankrupting the American people. I urge support of this plan.

The SPEAKER pro tempore. The gentleman from New York has 3½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin, RON KIND, and thank him for yielding.

Mr. KIND. I ask my colleagues to support true reform and provide all Americans with access to affordable and quality care that they all deserve.

Mr. RANGEL. Mr. Speaker, I yield myself the balance of my time.

I’m not going to be as difficult with the Republicans as some of my colleagues because I’m glad at the end of the day they finally understood the problem. And even though it was only Tuesday that they actually put something together for us to look at, at least we know that some of them are going in the right direction.

It’s going to be tragic to explain this to the American people not only now but in the future as to when they had a great opportunity. They lost it on Social Security. They said government is too big. They lost it on Medicaid. They said they didn’t want to see the President fail. They lost it on Medicare. They said the benefits were too much for the poor folks, that they should have freedom instead of health care. And they certainly lost it in
Medicare where they made it appear as though it was going to be a Big Government takeover. And now it just seems to me that they've proven how well government can do in these programs. And the fact that in lieu of just plain freedom, in lieu of that they can get insurance if they're at risk, the whole idea that they're proud of people who cannot afford to do this at least to have the opportunity to do it.

So, Mr. Speaker, I just hope that some of those on the other side might allow morality to go beyond just party loyalty.

At this time it gives me pleasure to present to this body Chairman Waxman, who has done so much to make this a reality.

Mr. CAMP. Mr. Speaker, I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I'm pleased to yield 1 minute to the gentleman from Vermont (Mr. Welch).

Mr. WELCH. Mr. Speaker, tonight the question before Congress is neither new nor complicated: Will we do what it takes to make health care affordable and available to all Americans?

Our predecessors in Congress faced similar problems when they extended voting rights to all Americans, established Social Security and Medicare for all seniors. Mr. Speaker, Congress faced those challenges and we are the better for it. We did so without conflict, with coverage but with some bipartisan support.

Tonight is different, unique. Our Republican friends have assured us that not a single member of their caucus will vote for health care reform. Every single person will vote “no.”

The Republicans’ alternative says to Americans with a preexisting condition, you are on your own. To the 47 million Americans without insurance, you're on your own. To the millions of Americans with a preexisting condition, a heart of stone. If you kicked them in the heart, you would break your toe.

They say that the Democratic plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill and not the Republican bill. The Republicans claim the Democratic bill will hurt seniors, but AARP has endorsed the Democratic bill and not the Republican bill. Why does AARP support the Democratic bill? Because the Democratic bill will close the Medicare part D doughnut hole for seniors. The Republican bill does not. We provide support for low-income seniors; they do not. We will extend the solvency of Medicare; they do not. Right now 60 percent of all bankruptcies in America are because of medical expenses. The Democratic bill makes sure that never happens again; the Republican bill does not.

You know, the GOP used to stand for Grand Old Party. Now it stands for “grandstand, oppose, and pretend.” They grandstand with phony claims about nonexistent death panels. They oppose any real reform. And with this substitute they offer a solution while really doing nothing. GOP: grandstand, oppose, and pretend.

And make no mistake about it, the Republican substitute is not real reform. It does nothing to curb skyrocketing health care costs. It does nothing to provide real insurance coverage to millions who are now uninsured. It does nothing to stop the unfair practices of insurance companies.

I urge my colleagues to vote “no” on the Republican “do-nothing” substitute.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. Mica).

Mr. MICA. Mr. Speaker, this is a sad day for Americans who lack health care coverage. While Democrat efforts to resolve health care problems may be well intended, in fact they totally miss the mark. People want lower premiums, increased access, less cost, and less red tape. They want choice and quality health care.

Instead, the Democrat health care plan dramatically expands government, cuts Medicare, and imposes significant costs on the taxpayers. The creation of 118 new Federal programs, agencies, and czars adds bureaucracy and red tape rather than providing a cure to bring health care costs down and accessibility up. The $729 billion in new taxes on Americans and small businesses will result in a loss of 5.5 million more jobs at a time when our country can least afford it and unemployment has topped a record 10.2 percent.

I oppose the cuts of nearly a half trillion dollars in Medicare. This is the wrong solution at the wrong time.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 1 minute to the gentleman from Texas (Mr. Gonzalez).

Mr. GONZALEZ. Mr. Speaker, I rise in strong opposition to the substitute. This substitute includes medical liability reforms that draw on the Texas model. I'm from Texas. Let me tell you about the Texas experience.

We were promised that medical malpractice reform in Texas would result in attracting doctors to underserved areas. Today, Texas ranks 43rd out of the 50 States in the number of doctors per capita.

We were promised that it would rein in health care costs. Health care costs in Texas with Medicare alone rose 24 percent in the 3 years after Texas tort reform.

We were told that it would reduce the cost of health care insurance for Texans. Premiums actually increased 86.8 percent from the years 2000 to 2007. The average insurance policy for a family in Texas went from $6,636 to $12,403.

Mr. Speaker, tonight, I urge my colleagues to vote “no” on the substitute.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 2 minutes to the gentleman from New York (Mr. Weiner).

Mr. WEINER. You know, there are honorable people on both sides of this debate; but there are moments that come along, and they come along about every generation or so, that make it clear why this side of the aisle are Republicans and why we're Democrats. In 1935 when there was the Social Security Act and we decided we weren't going to allow 30 percent of seniors to slip into poverty, Democrats proposed, Democrats passed; Republicans opposed Social Security.

In 1965 when Medicare was passed, Democrats proposed, Democrats supported; Republicans opposed, and now Medicare is a fact of life. And the very same arguments that were made against Medicare then are being made tonight.

I hear this talk about the single payer plan that's going to creep over. I can tell you I wanted a single-payer plan. I would like it to be there, but it's not. But you opposed it then, and now you claim to support it.

There's been a lot of talk about how big the bill is, but here's what it's all about: this is what Members of Congress get. This is a guidebook with affordable health care plans, many choices, deep discounts because we pool people together, minimum standards for each plan. This is what Members of Congress get, but they don't want you, the American people, to get it.

This is what it's about: they say they want to protect Medicare, but it was
they who wanted to eliminate it. They say they want to protect Social Security. It was they who wanted to privatize it. Now they say we don’t want to cover those who are uninsured because you shouldn’t care.

Well, I say to my colleagues, who pay those bills? The bill fairy? Who pays those bills are you, the taxpayer. They say they want you to pay those, too.

When you look at how big the bills are, remember this document. Eight million Americans who work for the Federal Government, including my colleagues, get this document in the mail. They get good health care. We want it for you. They’re going to get Medicare at 65. They don’t say we don’t want Medicare because we don’t believe in single-payer. They want it because they want to take and take and take, but they don’t want it for you.

The Democrats want this for you and the Republican Party just wants it for themselves.

Their plan cuts Medicare benefits to seniors. Ours retains them.

Their proposal blows a hole in the deficit. Ours actually saves money.

Their bill imposes penalties and mandates on our small businesses that cost jobs. Ours doesn’t.

Specifically, Mr. Speaker, our bill will help you access health care if you lose or change your job. And it will ensure that you have access to medical care if you have a preexisting condition. And we also, Mr. Speaker, deliver on something that the majority refuses to even talk about, and that’s real, meaningful medical liability reform.

And most importantly, Mr. Speaker, we produce cost savings for workers, families, and small businesses. The Congressional Budget Office says that the Democrats’ new government-run system won’t reduce costs. CBO says our legislation lowers health care costs. In fact, CBO says that the Republican plan cuts premiums by up to 10 percent for those covered by small businesses, up to 8 percent for those not covered by employers, and up to 3 percent for employees covered by large businesses.

Mr. Speaker, in the face of 10.2 percent unemployment, Americans want jobs. They want less government spending and more economic security. The majority’s bill shows they have not listened. Ours shows we have.

Interestingly, Mr. Speaker, the only bipartisan on Capitol Hill today will be in opposition to Speaker Pelosi’s trillion-dollar-plus government overhaul of America’s health care system.

With that, Mr. Speaker, I urge passage of this substitute.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that the 2 minutes that has been reserved for the Education and Labor Committee debate time in opposition to the Republican substitute be transferred to the Energy and Commerce Committee’s time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding and for the extraordinary kindness that he and others have done on this bill.

The extraordinary diversity of our Democratic Caucus, Mr. Speaker, from right to left, has ensured that this bill represents a cross-section of our country—urban, suburban and rural. The incredible diversity of our Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas meant that we could come to this floor today only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured.

Thus, there can be no doubt that the Affordable Health Care for America Act is a balanced bill and the best bill for the citizens of the United States of America.

The extraordinary diversity of our Democratic Caucus—from right to left has ensured that this bill represents a cross-section of the our country—urban, suburban, and rural. The incredible diversity of our Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could come to this floor today only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured.

The bill’s greatest achievements are that it would reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; would end discrimination by insurers who dropped or refused to renew or sell coverage because of health status and would ensure that coverage is affordable by providing subsidies for people in employer-based health care or through an insurance exchange of private insurers and a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

PARLIAMENTARY INQUIRY

Mr. GOHMERT. Parliamentary inquiry.

Mr. GOHMERT. Mr. Speaker, my understanding of the rules is that there is required to be a copy of the bill, and since we have a manager’s amendment, that is supposed to be somewhere. A number of members have been trying to find a copy of the manager’s amendment since we are going to be voting on it. I hear some ahas, but isn’t there supposed to be a copy, and if so, where would that copy be, since we are about to do this to the American people?

The SPEAKER pro tempore. The official papers are at the desk.

Mr. GOHMERT. Mr. Speaker, as just at the desk, Mr. Speaker, so parliamentary inquiry: If you could direct me to that place on the desk where the 200 pages are, it would be very helpful.

The SPEAKER pro tempore. The Clerk has the official papers. Additional copies are in the lobby and Members have been carrying them around all day.

Mr. GOHMERT. Parliamentary inquiry. Does the Speaker know where a copy, as the rule requires, is at the desk so that we can come up and see it at the desk as a requirement of the rules?
The SPEAKER pro tempore. The Clerk has custody of the official papers.

Mr. GOHMER. I take that as a "no."

The SPEAKER pro tempore. The gentleman from Michigan has 4 minutes remaining, and the gentleman from California has the right to close.

Mr. CAMP. We will reserve our time.

Mr. WAXMAN. We are ready to close, so use your time. Use it or lose it.

Mr. CAMP. At this time, Mr. Speaker, I yield the customary 1 minute to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Let me thank my colleague for yielding, and thank him and our ranking members for the job they have done putting our substitute together.

Ladies and gentlemen, before I came here, I ran a small business. While I was running my small business, it became pretty clear to me that government was growing in my view out of control. More regulations, more taxes, more compliance costs, both for my suppliers, for my customers, and for my own little small business. It seemed to me that government was choking the goose that was laying the golden egg.

You know, we were all lucky enough to be raised in America, most of us born in America, the greatest country in the world. America is a great country because Americans have had the freedom, the freedom to succeed, the freedom of opportunity. But I think all of us can understand that the bigger government gets, the more that it takes from the American people, the more money that individuals have to spend to comply with all of these regulations, is less money that is left in American families’ pockets, small business’s pockets, and as a result the opportunities, the opportunities available for our children so diminished.

We live in a great country. But it can only be great if we are willing to allow the freedom that Americans have had to succeed to remain. That freedom has been dimming. The bright lights of freedom have been dimming for decades because government continues to grow. One only has to look at what has happened this year to wonder why we are here tonight doing this. We all know we have had a difficult economic shock in our country over the last year.

So we see a stimulus bill that came to this floor with a promise that we were going to create jobs, jobs, jobs. And unemployment wasn’t going to exceed 8 percent. Not only do we have unemployment rates at 10.2 percent and over 3 million Americans have lost their jobs. So all of a sudden we have a budget on the floor, a trillion-and-a-half-dollar deficit this year, and trillion-dollar deficits on average for as far as the eye can see. And I don’t think there’s a Member on either side of the aisle who doesn’t realize that this is unsustainable, that this will wreak havoc on our country and wreak havoc on the future for our kids and our grandkids.

If there is one obligation that we have, it is to ensure that the American dream that is available to all of us is available for our kids and our grandkids. And trillion-dollar deficits for as far as the eye can see are not sustainable and will ruin their future.

But no, it wasn’t enough. All of a sudden we have to have this national energy tax on the floor in June. It is called cap-and-trade because no one in America really knows what that means, but it is a giant energy tax. And it would tax anybody who drives a car, anybody who works at a place that uses electricity. Anyone who would have the audacity to flip on a light switch is going to pay a higher tax.

Not only are we going to pay higher taxes and have less energy and higher energy costs in America, it will ship millions of American jobs overseas at a time when Americans are asking, Where are the jobs? And the policies that have been coming down the pike all year have more than diminished the possibility that we will be creating the jobs that Americans so desperately want. That still wasn’t enough. Now we are going to bring this 2,000-page bill to the floor of the House.

It’s full of mandates. And as insurance premiums for those who have health insurance are going up, and those who have their job can keep it. What has happened here all year is we’re moving policies that are going to destroy the ability of the private sector to create those jobs. But I don’t think there is anything that will diminish the job prospect in America more than what has happened this year, than this health care bill.

Now, you just think about this bill that we have in front of us. It is going to raise taxes. It is going to raise insurance premiums for those who have insurance. It’s full of mandates. And as if that’s not enough, we are going to cut Medicare.

Now, the President said that if you like the health insurance you have, you can keep it. And I know the President was sincere in that, but that is not what this bill represents and there’s not a Member in this Chamber that doesn’t understand that. Because if you’re a Medicare Advantage enrollee, like 2700 of my constituents, the Congressional Budget Office says that 80 percent of them are going to lose their Medicare Advantage.

Now, if you look at this bill and you look at the employer mandate in this bill, you will find out that if employers don’t prove with certainty that there is a tax. And for many employers, the tax will be cheaper than the actual cost of health insurance. A lot of employers in America are going to look up and say, Listen, I’d rather pay the tax, and my employees are going to have to go fend for themselves and end up in the government plan.

But it doesn’t stop there. This bill and the plan that is offered today has to be approved once again by the Department of Labor and the health choices czar; big compliance cost there. Some employers are going to say, Listen, this isn’t worth it. But no, it’s not. It’s not just going to be the employer mandate that is approved again. It’s going to go through the health choices czar so that the health choices czar can determine whether your plan is adequate according to some Federal bureaucrat. And so a lot of employers, they’re just going to get out of it. They’re not going to do it. And what is going to happen to those employees who like the coverage they have today? They are going to end up in the government plan.

But no, no, it doesn’t stop there. We have an individual mandate in this bill. If you look at the exchange that’s in this bill in front of us that says every American is going to buy health insurance whether you want it or not. And if you don’t want it, you’re going to pay a tax. And if you don’t pay the tax—listen to this. If you don’t pay the tax, you’re going to be subject to a fine of up to $250,000 and imprisonment up to 5 years. Now, this is the most unconstitutional thing I’ve ever seen in my life.

The idea that we can tell Americans, force Americans by this law, that they have to buy health insurance or we’re going to fine you and send you to jail.

But there has been all this focus on the employer mandate and on the individual mandate, on the government opinion, but let me tell you where there hasn’t been much attention, and that is the giant bureaucracy that is being built here in Washington in the Federal Government to take control of Americans’ health care system and force you out of the insurance you have and into some government-run plan.

I know most of my colleagues, they might think this is hyperbole or it might sound political. Let me tell you, it isn’t. Well, just listen to this. Most of my colleagues on the left have been down here today. They are for this because it does in fact set up this big infrastructure for the government to eventually take control of all of our health care and just go to a single-payer system.

Now, it starts with the exchange that’s in this bill. Once it takes effect, the health exchange, you can’t buy private insurance on your own. You can’t go out and buy insurance. You have to go to the exchange, and the exchange will decide for you which plans are offered to you. So, if you change your job or you don’t like what you have, guess what? You get to go to the government’s health exchange to get your insurance.

But no, it’s just not the government option that I’m talking about. When you look at this infrastructure that’s there, it is going to require tens of thousands
of new Federal employees. The American people want two things from health care reform: They want lower cost and they want more choices. I think the underlying bill here tonight does exactly the opposite. It raises the cost of health insurance and creates more bureaucracy. This new agency would make health care decisions that should be left to doctors and their patients.

So let’s talk about this bureaucracy for a moment. If you go to page 131, section 241, it provides for an unelected “Health Choices Commissioner” who would run a “Health Choices Administration,” an independent agency of the executive branch.

Now, here are some of the examples of the powers of this new health choice commissioner—let’s just call him the health czar. On page 167 through 172, in section 303, the health czar will decide which treatment patients could receive and at what cost. Or you can go to page 132, section 242, the health czars would run which private plans would be allowed to participate in the exchange.

Then you go to page 127, section 234. This new health czar will regulate all insurance plans both in and out of the exchange.

Then you go to page 162 to 165, section 302, the health choices czar will determine which employers are going to be allowed to participate in the exchange.

Then you go to page 174 to 178, section 303(b), the health choices czar will decide which physicians and hospitals get to participate in the government-run plan.

Then you go to page 197 to 202, section 306, the health choices czar will determine which States are allowed to operate their own exchange and to terminate any previously approved State exchange at any time.

Then you go to page 170 and 171, section 307(b), the health choices czar can override State laws regarding covered health benefits. It’s in the bill. Go read it.

Page 133, section 242(a)(2). This person will determine how trillions of taxpayer and employer dollars would be spent within the exchange.

And page 133, section 242, “compertent random compliant audits.” The person still has more powers here.

Page 183, section 306, automatically enroll individuals into the exchange if they don’t have coverage, including potentially forcing these individuals into the government-run plan. Now, this is referred to as “random assignment.”

This commissioner is charged with establishing “waiting lists” and defining such terms as “dependent,” “service area,” “premium rating area,” “employee,” “part-time employee,” and “full-time employee.” Let’s all be honest, this is the czar to end all czars.

But it doesn’t stop there. When you look at this expanding bureaucracy created in the Federal Government, on page 1322, section 2401, it creates a new Center for Quality Improvement to prioritize areas for identification, development, evaluation, and implementation of best practices for quality improvement of best practices for the delivery of health care services. We’ve already got Centers for Quality Improvement, but we don’t need another one in the Federal Government, on page 1183, section 1904 provides for a Public Health Workforce Corps for the purpose of “ensuring an adequate supply of health professionals.” The bill also creates a “Public Health Workforce Scholarship Program” and a “Public Health Workforce Loan Forgiveness Program.” All of this duplicates the existing National Health Services Corps.

Page 1478, section 2552, the bill creates an Emergency Care Coordination Center in the Office of the Assistant Secretary for Preparedness and Response charged with working in coordination with the Federal Interagency Committee on Emergency Medical Services. And the Emergency Care Coordinator Center seeks out the advice of a Council of Emergency Care.

Do we not finish yet? How about this one? Page 1515, section 2572(b) imposes a labeling requirement on all vending machines nationwide. In addition to that, we require all restaurants with more than 20 locations to post the calorie count on the menu and we spell this out in the law—right next to the menu, whether it’s the drive-in menu, the menu on the board, the one they hand out to you. Oh, yeah. We’re going to require every restaurant with more than 20 locations to do this. Oh, but that’s not enough.

Page 872, section 1433 requires the director of food services at nursing facilities that participate in Medicare or Medicaid to hold “military, academic, or other qualifications” as determined by Federal bureaucrats. So now we are going to legislate the work requirements in the background of all this off.

But I think this is the best part of the bureaucracy: on page 122, section 233(a)(3) of this 2,032-page bill, it requires the commissioner to “issue guidance on best practices of plain language.” Oh, yes, it’s right here in the bill. Go look at it.

Ladies and gentlemen, we know what’s going on here. There are problems in our current health care system that we all want to address. I heard all the criticisms of our bill and the fact that it doesn’t do everything that everybody wants it to do.

But do you know what it does do?

It lowers the cost of health insurance, and it solves the problem of those with preexisting conditions, and it begins what the American people want, a step-by-step approach to making the best health care system in the world better.
We can do that. What we don’t need to do is create this giant bureaucracy, spend all of this tax money, and imprison our children’s future by passing this 2,000-page bill.

So, I think we do have a better solution, a commonsense solution that Americans want.

So, tonight, here we are. We have a choice. We can pass the 2,000-page bill. We can raise taxes. We can cut Medicare. We can impose all of these mandates that are going to drive employment down and unemployment up, or we can take some commonsense approach.

As I said during my remarks, our job is to do our best to make sure that our kids and grandkids have a better chance of the American Dream than we did. I understand that we’ve got some tough choices to make, but that’s what the American people sent us here to do is make those tough choices. I’m not going to put my kids further in debt. I’m not going to dim the lights of freedom for my kids and theirs nor for anyone’s in this country if I can avoid it.

So we have a choice. We can do what’s right for the future, or we can continue down this path toward bigger and bigger government. I came here to fight for freedom. I came here to renew the American Dream for our kids and our grandkids.

So I would ask my colleagues to think about that choice. Vote for the Republican alternative, and whatever you do, please vote “no” for the underlying bill.

Mr. WAXMAN. Mr. Speaker, to close the debate on the Democratic side, I yield the balance of my time to the dean of the House, to the lead author of the underlying bill and to a man who has fought longer for national health insurance than anyone in this institution. I yield the balance of my time to Representative JOHN DINGELL from the State of Michigan.

The SPEAKER pro tempore. The gentleman from Michigan is recognized for 5 minutes.

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

Mr. DINGELL. Mr. Speaker, I am here tonight to urge my colleagues to vote against the Republican substitute and for the bill reported by three committees after long and hard work.

I want to tell the House—all Members—how proud I am of the discussion that has taken place today. I want to commend the three committees and their chairmen, including my good friend, the chairman of our committee, Mr. WAXMAN, for the work they have done.

You, Madam Speaker and the leadership, we thank you for the extraordinary leadership which you have given us in bringing this to the point where we are tonight. Thank you.

I want to begin by spending much time on the bill offered by my Republican colleagues. It is really no substitute for H.R. 3962. According to The New York Times—and I think this sufficiently disproves of the matter—the Republican amendment does “almost nothing to reduce the scandalously high number of Americans who have no insurance, and it makes only a token stab at slowing the relentlessly rising costs of medical care.”

Interestingly enough, under the Republican amendment, individuals would pay up to $2,821 more, and families would pay up to $8,188 more under the Republican alternative as compared to H.R. 3962. It’s not in the public interest that we should do that.

Having said that, this is historic legislation. It addresses two of the most terrifying problems we have in this country.

The first is what was the problem when my dad introduced the first legislation in 1943, that there are now some 47 million Americans without health insurance. It can’t have been canceled by your insurance company when you’re going to the doctor. It can’t have been canceled by your insurer that morning that you’re going to be standing between him and the doctor so that you can’t have health insurance. It can’t have been canceled by your insurer that morning that you’re going to stand between the insurance bureau- and the insured. It is going to permit the government to stand between the insurance bureaucrat and the insured, and it is going to stand between him and the doctor so that the doctor can provide the care he wants.

The problems this historic legislation aims to address are real and worsening for American citizens, business, and governments. When my Dad introduced this legislation sixty some years ago, it was a simple humanitarian problem. Today it is one of impending economic disaster to America.

H.R. 3962 meets the goals President Obama outlined for us earlier this year: it is deficit neutral; it provides coverage for 96 percent of Americans; and it offers everyone, regardless of income, age or health status, the peace of mind that comes from knowing they will have real access to quality, affordable health insurance when they need it; that pre-existing conditions will not bar them from insurance; that loss of job or dropping of coverage by employer will not deny insurance.

This bill will stop discrimination against people with pre-existing conditions, and it will stop rescission—the practice in which an insurer searches for problems with patients’ policies while they are waiting on a gurney for emergency care.

Additionally, this bill will ensure choice and honest competition; bring security to our seniors; and it will reduce the out-of-control health care costs that are crushing American businesses.

Now is the time for health care reform. We can’t afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.

Mr. Speaker, I have heard from a number of my colleagues, and I appreciate the fact the vote before us today is a tough vote. I understand there are numerous compelling issues confronting the American people—the economy, jobs, financial system overhaul. That was so in 1935 when we passed Social Security. I hear my colleagues tell us that the economy, jobs and financial system overhaul, are desperately needed. True. But that was the case in ’35 when we passed the Social Security Act.

Now I hear my Republican colleagues tell us this is going to stand between— or permit a government bureaucrat to stand between the insured and the doc- tor and each other. In point of fact, it is going to permit the government to stand between the insurance bureau- crat and the insured, and it is going to stand between him and the doctor so that the doctor can provide the care he wants.

My problems this historic legislation aims to address are real and worsening for American citizens, business, and governments. When my Dad introduced this legislation sixty some years ago, it was a simple humanitarian problem. Today it is one of impending economic disaster to America.

H.R. 3962 meets the goals President Obama outlined for us earlier this year: it is deficit neutral; it provides coverage for 96 percent of Americans; and it offers everyone, regardless of income, age or health status, the peace of mind that comes from knowing they will have real access to quality, affordable health insurance when they need it; that pre-existing conditions will not bar them from insurance; that loss of job or dropping of coverage by employer will not deny insurance.

This bill will stop discrimination against people with pre-existing conditions, and it will stop rescission—the practice in which an insurer searches for problems with patients’ policies while they are waiting on a gurney for emergency care.

Additionally, this bill will ensure choice and honest competition; bring security to our seniors; and it will reduce the out-of-control health care costs that are crushing American busi- nesses.

Now is the time for health care reform. We can’t afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.

Mr. Speaker, I have heard from a number of my colleagues, and I appreciate the fact the vote before us today is a tough vote. I understand there are numerous compelling issues confronting the American people—the economy, jobs, financial system overhaul. That was so in 1935 when we enacted Social Security over just about the same objections.

However, we know that no issue has caused the American people to suffer longer than the issue of inaccessibility to health care.

History and the American people will ask what we did here this day when presented with a real opportunity to ease the strain of rising health care costs and provide quality, affordable health coverage for all.

Mr. Speaker, the vote for me today will be on behalf of American families who are forced to decide whether they will pay the mortgage or their health insurance premium.
My vote today is for American business—big and small. They are confronted with the real burden of providing quality health care for their workers or fall victim to their foreign competitors.

My vote today is for the federal government, and state and local governments throughout the country which are being stretched to make room for larger and larger health bills.

Mr. Speaker, my vote today is also personal.

It is a vote to fulfill the legacy left by a little, skinny old man with a broken nose and a mustache who served as a proud Member of this distinguished body.

My father, John D. Dingell, Sr., was a part of the original New Dealers—a brand of big thinking Democrats—who believed that health care is a right, not a privilege and government had a responsibility to protect it; provide for their basic rights; and ensure opportunity for all.

So, it is in that tradition that I urge my colleagues to act today to pass this bill.

Join with the AARP, the Consumers Union, the American Cancer Society, the different medical specialist groups, the nurses and others who support this bill.

Mr. Speaker, we have an opportunity today, to do something meaningful for the American people and for American business.

We can take advantage of this opportunity or we can shirk our responsibilities and allow the calamitous situation that faces our people to continue to grow out of hand, overwhelm the federal budget, force more and more families into bankruptcy, and shift more jobs overseas.

Reform is neither easy nor cheap, but the cost of inaction is far greater—in terms of lost lives, quality of life and dollars. If we don’t reduce costs we face certain economic disaster.

So, today, we must overcome the naysayers, the oppositional, the lies about our plan, the fear that causes us to think the status quo is the safe thing to do.

We must overcome all of these things and we must act boldly, with conviction, and deliberately—not because of our own righteousness—but because there is no other acceptable alternative.

I urge my colleagues to vote “yes” on H.R. 3962 and give the American people the relief they so desperately need.

Ms. RICHARDSON. Mr. Speaker, I rise today to oppose the Boehner amendment and in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

President Theodore Roosevelt proposed national health insurance in 1908. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens.

Today, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won’t bankrupt their families.

The health care system we have now is not working for working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured.

There are 54 million Americans who are uninsured who need us to reform this broken system. One in five Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, the Affordable Health Care for Americans Act is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It strengthens the NationalHealthCare for America Act of 2009, because today to oppose the Boehner amendment and ‘yes’ on H.R. 3962.

Mr. GALLEGLY. Mr. Speaker, I rise in support of the amendment offered by Mr. BOEHNER. I have long supported changes to the ‘donut hole for seniors. It ends the era of no preventive care while putting an annual cap on out-of-pocket expenses for American families.

Now, we need to stop playing politics and focus on actually improving people’s lives. H.R. 3962 will reform the health care system so that it provides quality, affordable coverage that cannot be taken away. It eliminates discrimination based on gender and preexisting conditions. It eliminates the prescription drug donut hole for seniors. It ends the era of no quality, affordable coverage for millions of Americans seeking coverage.

The hour is late, and the need is great. I urge my colleagues to vote “no” on the Boehner Amendment and “yes” on H.R. 3962.

Mr. Speaker, today, we must act boldly, with conviction, and deliberately to do something meaningful for the American people.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It strengthens the NationalHealthCare for America Act of 2009, because today to oppose the Boehner amendment and ‘yes’ on H.R. 3962.

Mr. Speaker, we have an opportunity today, to do something meaningful for the American people and for American business.

We can take advantage of this opportunity or we can shirk our responsibilities and allow the calamitous situation that faces our people to continue to grow out of hand, overwhelm the federal budget, force more and more families into bankruptcy, and shift more jobs overseas.

Reform is neither easy nor cheap, but the cost of inaction is far greater—in terms of lost lives, quality of life and dollars. If we don’t reduce costs we face certain economic disaster.

So, today, we must overcome the naysayers, the oppositional, the lies about our plan, the fear that causes us to think the status quo is the safe thing to do.

We must overcome all of these things and we must act boldly, with conviction, and deliberately—not because of our own righteousness—but because there is no other acceptable alternative.

I urge my colleagues to vote “yes” on H.R. 3962 and give the American people the relief they so desperately need.

Ms. RICHARDSON. Mr. Speaker, I rise today to oppose the Boehner amendment and in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

President Theodore Roosevelt proposed national health insurance in 1908. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens.

Today, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won’t bankrupt their families.

The health care system we have now is not working for working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured.

There are 54 million Americans who are uninsured who need us to reform this broken system. One in five Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, the Affordable Health Care for Americans Act is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It strengthens the NationalHealthCare for America Act of 2009, because today to oppose the Boehner amendment and ‘yes’ on H.R. 3962.

Mr. Speaker, today, I want to add my support for the Republican substitute amendment, the Commonsense Health Care Reform and Affordability Act. This amendment is a patient centered solution to healthcare reform that our country can afford and that members on both sides of the aisle can support. It also addresses the number one concern on the mind of all Americans in this country: the high cost of healthcare.

The Congressional Budget Office has estimated that this Republican substitute amendment would reduce health insurance premiums by up to 8 percent for those families who currently do not have access to employer-provided coverage. My constituents have told me personally that over against what healthcare is too high. They need healthcare that is more affordable, accessible and available and the Commonsense Health Care Reform and Affordability Act provides just that.

Included in the Republican substitute amendment is a new bill, H.R. 2607, the Small Business Health Fairness Act. This legislation allows small businesses to band together to purchase health insurance so they can enjoy the same bargaining power large corporations and labor unions have at the purchasing table. In all parts of our economy we know that buying in bulk reduces the price tag, and healthcare is no different. Government-priced healthcare is not the way to solve our health care problem. We can and have to do better.

With almost 60 percent of the uninsured population tied to a small business, this proviso in the Commonsense Health Care Reform and Affordability Act, helps bring access to affordable healthcare to those that currently don’t have it. Clearly, there are better ways to make healthcare more accessible for American families—and this Republican substitute is it.

Real healthcare reform should protect doctors and hospitals from frivolous lawsuits, so they can stop practicing defensive medicine and instead focus on practicing patient-focused medicine. This amendment extends medical liability reform that has been successful in several States to the rest of the Nation, saving lives and saving money.

Another provision in the Republican substitute amendment I am proud to support is the State Innovations Program. The amendment provides incentives to States who adopt reforms that reduce the cost of health insurance and expand coverage to the citizens of their States.

This provision allows States the freedom to solve their unique problems in their own way. Speaker PELOSI’s health-care bill focuses on the Federal Government trying to fix what is broken with our health care. But in my great State of Texas, I believe those that are best
The Commonsense Health Care Reform and Affordability Act contains a provision that will create a pathway for new, life saving products while maintaining the proper incentives for companies to research and strive to discover them. Most importantly, this provision will ensure that many of the jobs created in this industry will stay in the United States.

Mr. Aderholt, from Ohio (Mr. BOEHNER) on which the question is on the amendment offered by the gentleman from Ohio (Mr. BOEHNER). The SPEAKER pro tempore. The amendment printed in part D by Mr. BOEHNER of Ohio.

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, further proceedings on this question will be postponed.

The SPEAKER pro tempore. The amendment printed in part C by Mr. STUPAK of Michigan. Amendment printed in part D by Mr. BOEHNER of Ohio.

The Chair will reduce to 5 minutes the time for any electronic vote after the first vote in this series.

Amendment offered by Mr. STUPAK

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, proceedings will now resume on the amendments printed in parts C and D of House Report 111-330 on which further proceedings were postponed, in the following order:

1. Amendment printed in part C by Mr. STUPAK of Michigan.
2. Amendment printed in part D by Mr. BOEHNER of Ohio.

The vote was taken by electronic device, and there were—yeas 240, nays 194, answered “present” 1, not voting 0, as follows:

<table>
<thead>
<tr>
<th>Yeas</th>
<th>Nays</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>240</td>
<td>194</td>
<td>1</td>
</tr>
</tbody>
</table>

Mr. COHEN and Ms. JACKSON-LEE of Texas changed their vote from “yea” to “nay.” Messrs. SPRATT and LEWIS of California changed their vote from “nay” to “yea.” So the amendment was agreed to. The result of the vote was announced as above recorded. A motion to reconsider was laid on the table.

Amendment offered by Mr. BOEHNER

The SPEAKER pro tempore. The unfinished business is the vote on the amendment offered by the gentleman from Ohio (Mr. BOEHNER) on which the yeas and nays were ordered. The Clerk will redesignate the amendment. The Clerk redesignated the amendment: The SPEAKER pro tempore. The question is on the amendment. This is a 5-minute vote. The vote was taken by electronic device, and there were—aye 256, noes 208, not voting 0, as follows:

<table>
<thead>
<tr>
<th>Yeas</th>
<th>Nays</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>256</td>
<td>208</td>
<td>0</td>
</tr>
</tbody>
</table>
So the amendment was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 930, the previous question is ordered on the bill, as amended.

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

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

MOTION TO RECOMMEND

Mr. CANTOR. Mr. Speaker, I have a motion to reconsider the bill.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CANTOR. Yes, Mr. Speaker, in its current form.

The SPEAKER pro tempore. Pursuant to House Resolution 930, the motion is considered as read.

The text of the motion is as follows:

Mr. Cantor moves to reconsider the bill, H.R. 3962, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendments:

Page 1200, after line 15, insert the following new title and conform the table of contents of title B, and the table of divisions, titles and subtitles in section 1(b), accordingly:

TITLE X—SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND

SEC. 1191. FINDINGS.

Congress finds the following:

(1) When analyzing the Medicare cuts contained in division B, OACT predicts that, on average, Medicare hospital reimbursement rates are 20 percent lower than the reimbursers physicians receive from private health plans.

(2) Medicare geographic payment inequities are well documented and have been extensively studied.

(3) The Medicare Payment Advisory Commission (MedPAC) found that 28 percent of seniors currently have difficulty finding a new physician to treat them.

(4) Medicare geographic payment inequities are wide and documented, and have been extensively studied.

(5) The Medicare Payment Advisory Commission (MedPAC) found that 28 percent of seniors currently have difficulty finding a new physician to treat them.
to ensure that every Medicare beneficiary continues to have access to at least 1 Medicare Advantage plan under part C of the Medicare program.

(C) Provision of medically necessary care and treatment.—By providing such additional funding as may be necessary to ensure access by Medicare beneficiaries to medically necessary care and treatment furnished by physicians, hospitals, and other health care providers under the Medicare program, without wait lines or coverage determinations based solely on the basis of cost.

(2) High quality, low-cost county defined.—In this subsection, the term “high quality, low-cost county” means a county (or equivalent area) in which, as determined by the Secretary—

(A) the quality of care exceeds the national average; and

(B) the per beneficiary fee-for-service Medicare costs are substantially lower than the national average.

(c) Pinnung.—(1) In general.—There shall be available to the Fund—

(A) $15,500,000,000 for expenditures from the Fund during the 5-year period beginning in 2010; and

(B) $40,500,000,000 for expenditures from the Fund during the 5-year period beginning in 2015.

Such amounts reflect savings in Federal expenditures and increases in Federal revenues estimated to result from the provisions of division III.

(2) Funding limitation.—Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines, by a process of the Council of Actuaries of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

Add at the end the following (and conform the table of divisions, titles, and subtitles in section 2 of this division as necessary) after subtitle (b) accordingly:

DIVISION E—ENACTING REAL MEDICAL LIABILITY REFORM

Sec. 4101. Encouraging speedy resolution of claims.

Sec. 4102. Compensating patient injury.

Sec. 4103. Maximizing patient recovery.

Sec. 4104. Additional health benefits.

Sec. 4105. Punitive damages.

Sec. 4106. Authorization of payment of future damages to claimants in health care lawsuits.

Sec. 4107. Definitions.

Sec. 4108. Effect on other laws.

Sec. 4109. States’ rights.

Sec. 4110. Punitive damages.

Sec. 4111. Authorization of payment of future damages to claimants in health care lawsuits.

Sec. 4112. Definitions.

Sec. 4113. Effect on other laws.

Sec. 4114. State flexibility and protection of states’ rights.

Sec. 4115. Applicability; effective date.

SEC. 4101. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

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

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years from the date of manifestation of injury or prior to the minor’s 8th birthday, whichever provides a longer period.

Such time limitations may be tolled for minor for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or conspiracy to bring an action on behalf of the injured minor.

SEC. 4102. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC AND NONECONOMIC DAMAGES.—In any health care lawsuit, nothing in this division shall limit a claimant’s recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of non-economic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NON-ECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the amount of the award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, at the discretion of the judge, or after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future non-economic damages are reduced first.

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

SEC. 4103. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims the income from a contingency fee for the payment of damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s);

(2) 35 percent of the next $50,000 recovered by the claimant(s);

(3) 25 percent of the next $500,000 recovered by the claimant(s);

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In any action against an individual involved in a health care lawsuit, a court shall not reduce the fees that the court shall consider only the following—

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

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

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

(4) the number of products sold or medical procedures rendered for compensation, as the

SEC. 4104. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid to the claimant in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a final judgment. The section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396(a)(25)) of the Social Security Act.

SEC. 4105. PUNITIVE DAMAGES.

(a) In general.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such persondeliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon application for court supervision in the first two years of the lawsuit, each party shall be liable for that party’s several share of any damages only and not for the damages to any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party in the amount of damages allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility for each party for the claimant’s harm.

SEC. 4106. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims the income from a contingency 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. In no event shall the total of all contingent fees for representing claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s);

(2) 35 percent of the next $50,000 recovered by the claimant(s);

(3) 25 percent of the next $500,000 recovered by the claimant(s);

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In any action against an individual involved in a health care lawsuit, a court shall not reduce the fees that the court shall consider only the following—

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

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

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

(4) the number of products sold or medical procedures rendered for compensation, as the

H12964 CONGRESSIONAL RECORD — HOUSE November 7, 2009
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.
(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.
(2) The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages, whichever is greater. The jury shall not be informed of this limitation.

SEC. 4106. 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 any health care lawsuit, the court may be governed by the Uniform Periodic Payment of Judgments Act adopted 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 division.

SEC. 4107. DEFINITIONS.
In this division—
(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that includes 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 any 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 behalf of the claimant or the claimant’s estate, 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 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, goods, medical products, or professional or expert employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), loss of enjoyment of consortium (other than loss of domestic services), loss of employment, and loss of business or employment opportunities.
(5) CONTINGENT FEE.—The term “contingent fee” includes all compensation to any person charging or paid on a contingency basis which is payable only if recovery is effected on behalf of one or more claimants.
(6) ECONOMIC DAMAGES.—The term “economic damages” means economic damages and noneconomic damages, as such terms are defined in this section.
(7) HEALTH CARE LAWSUIT.—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services, or medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services, or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability upon which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in anti-trust.
(8) HEALTH CARE LIABILITY ACTION.—The term “health care liability action” means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability upon which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action in which the claimant alleges a health care liability claim.
(9) HEALTH CARE LIABILITY CLAIM.—The term “health care liability claim” means a demand by any person, whether or not pursuing a health care lawsuit, for compensation by any health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, punitive damages, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services, goods, medical products, regardless of the theory of liability upon which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of claims or causes of action.
(10) HEALTH CARE ORGANIZATION.—The term “health care organization” means any person or entity which is obligated to provide or pay for (or fail to provide or pay for) health care services, goods, 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.
(11) HEALTH CARE PROVIDER.—The term “health care provider” means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, to provide services that include the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.
(12) INFELICIOUS INTENT TO INJURE.—The term “infelicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.
(13) INJURY.—The term “injury” means injury to property sustained, except for damage to personal property that is in the possession of a consumer or owner for personal use.
(14) MEDICAL PRODUCT.—The term “medical product” means any product used in the diagnosis, prevention, treatment, or cure of disease, but does not include medical services, any device, drug, or biological product intended for humans, and the terms “medical device” or “biological product” shall have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and 321(h)), and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively.
(15) NONCOMPENSATORY DAMAGES.—The term “noncompensatory 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 noneconomic losses of any kind or nature.
(16) 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, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor non-economic damages.
(17) RECOVERY.—The term “recovery” means the net sum recovered after deducting any costs and expenses or 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 provided by the claimant and any attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.
(18) STATE.—The term “State” means each of the several States, the District of 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. 4108. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—
(1) 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 division does not affect the application of the rule of law to such an action; and
(B) any rule of law prescribed by this division in conflict with a rule of law of such title shall not apply.
(2) If there is an aspect of a civil action brought for a vaccine-related injury or death

H12965

November 7, 2009

CONEGRESSIONAL RECORD — HOUSE

that is inconsistent with the requirements of the Federal program, the provisions of this division shall control over any inconsistent provisions of the Federal program.

H12965

November 7, 2009

CONEGRESSIONAL RECORD — HOUSE

that is inconsistent with the requirements of the Federal program, the provisions of this division shall control over any inconsistent provisions of the Federal program.
to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this division or otherwise applicable law (as determined under this division) will apply to such aspect of such action.

(b) Other Federal Law.—Except as provided in this section, nothing in this division shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 4109. STATE FLEXIBILITY AND PROTECTION OF STATES’ RIGHTS.

(a) Health Care Lawsuits.—The provisions governing health care lawsuits set forth in this division, if they preempt, subordi- nate to or otherwise override any State law regarding collateral source benefits, or mandate, or any provisions of law established by or under this division. The provisions governing health care lawsuits set forth in this division supersedethe chapter 171 of title 28, United States Code, to the extent that such chapters:

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or other provision of law that affects the periodic payment of future damages, than provided in this division; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) Other States’ Rights and Other Laws.—(1) Any issue that is not governed by any provision of law established by or under this division (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This division shall not preempt or supersede any State or Federal law that imposes additional or substantive protections for health care providers and health care organizations from liability, loss, or damages that those provided by this division or create a cause of action.

(c) State Flexibility.—No provision of this division shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this division, notwithstanding section 4102(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 4110. APPLICABILITY; EFFECTIVE DATE.

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

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia is recognized for 5 minutes in support of the motion.

Mr. CANTOR. Mr. Speaker, any physi- cian in America will tell you that the simplest way to reduce health care costs is to enact real medical liability reform. The fear of being sued by op- portunistic trial lawyers is pervasive in the practice of medicine. Our system wastes billions on defensive medicine that should be going to patient care. That’s why real medical liability reform is needed. In fact, CBO estimates that as much as $46 billion can be saved by the Federal Government alone. It is totally unacceptable that this money is being spent in the courtroom instead of the operating room.

At the same time, the majority has promised those people that their health care bill will lower costs, yet the bill before us today, Mr. Speaker, contains no medical liability reforms. And why not? The truth comes from one of the Democrats’ own, no less than former DNC Chair and physi- cian Howard Dean, who said last Au- gust. The reason that tort reform is not in the bill is because the people that wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the truth.

Mr. Speaker, the Republican motion to recommit adds real meaningful medical liability and reform and uses its $46 billion in savings to create a fund that will protect seniors, especially those in rural areas, from the steep cuts to Medicare in the Democrats’ reform package. It gives Members the chance to prioritize the health of our Nation’s seniors instead of lining the bank accounts of trial lawyers. It’s time to take control of the doctors’ offices, the clinics and the operating rooms and leave patient care to the people trained to handle it best—our doctors.

Mr. Speaker, to talk about this fur- ther, I now yield to the gentlewoman from Florida, Congresswoman BROWN-WAITE.

Ms. GINNY BROWN-WAITE of Flori- da. Betty, a constituent of mine, re- cently told me that if it weren’t for Medicare Advantage, she would be dead. We heard a lot from our friends on the other side of the aisle about something called medical liability reform, but all day as they’ve been talking about this point, you have not heard one word about patient safety. If you want to talk about real meaningful health care reform, it’s important to talk about the most critical aspect of true, meaningful health care reform—standing up for patients. Who will speak for the patients? Who will speak for the people who will speak for the patients? We have the reports from the highly respected nonpartisan Institute of Medicine on patient safety. The first one is on patient safety. Achieving a New Standard for Care. The second one is Preventing Medication Errors and To Err Is Human: Building a Safer Health System. What did the Institute of Medicine tell us about the state of patient safety? They told us that the most significant way to reduce the costs of medical malpractice is to emphasize patient safety by reducing the number of preventable medical errors. They also told us that’s the only way we’re going to our seniors. AARP put their profits ahead of our seniors.

With this motion, you have a chance to restore some of our cuts. No excuses about this amendment killing the bill can be made. No word games can get you out of this. This is the only way for seniors and Americans. Please re- member your constituents will be watching.

Mr. CANTOR. Mr. Speaker, I now yield to the gentleman from Washington, Mr. REICHERT.

Mr. REICHERT. Thank you. This motion was and will protect sen- iors from drastic cuts to Medicare and stop expensive lawsuits that increase the costs of health care for every American. We’ve heard, if you like it, you can keep it, but the bill before us is a direct assault on America’s seniors, cutting $500 billion from Medi- care.

Under this bill, one out of every five seniors will lose the health care plan they chose. Because of regional payment disparities in many parts of this country, Medicare Advantage plans are the only way seniors can receive needed care. It’s the only way that seniors can choose their doctors, and it’s the only way that seniors can choose the preventive treatment they need.

This motion is about choice. It’s about living in a free country. It’s about having freedom, Mr. Speaker, about the commonsense motion will protect seniors’ health care, lower health care costs, and preserve freedom.

Mr. HOYER. Mr. Speaker, I rise in opposition to the motion to recommit. The SPEAKER pro tempore. The gentle- man from Maryland is recognized for 5 minutes.

Mr. HOYER. Mr. Speaker, I yield to the gentleman from Iowa (Mr. BRALEY).

Mr. BRALEY of Iowa. Mr. Speaker, during this entire health care debate, we’ve heard a lot from our friends on the other side of the aisle about something called medical liability reform, but all day as they’ve been talking about this point, you have not heard one word about patient safety. If you want to talk about real meaningful health care reform, it’s important to talk about the most critical aspect of true, meaningful health care reform—standing up for patients. Who will speak for the patients? Who will speak for the people who will speak for the patients? We have the reports from the highly respected nonpartisan Institute of Medicine on patient safety. The first one is on patient safety. Achieving a New Standard for Care. The second one is Preventing Medication Errors and To Err Is Human: Building a Safer Health System. What did the Institute of Medicine tell us about the state of patient safety? They told us that the most significant way to reduce the costs of medical malpractice is to emphasize patient safety by reducing the number of preventable medical errors. They also told us that’s the only way we’re going to
They also told us that every year there are 15 million incidents of medical harm in this country and that patient safety is indistinguishable from the delivery of medical care. That’s why they aren’t telling you about what the Institutes of Medicine reported the cost of medical errors is in this country.

They reported in their studies that every year medical errors add $17 billion to $28 billion of cost, most of it in additional medical care that we end up paying for as consumers of health care. When you multiply that over the 10 years of this bill, that means it’s costing us $170 billion to $280 billion if we push this bill.

And, yes, they say something about equity. That’s what their objective is. That’s what they wanted.

Mr. HOYER. I thank the gentleman for his comments.

My colleagues, I ask you to reject this amendment. Our colleagues on the other side of the aisle demanded 72 hours’ notice for the bill and they’ve got it. I’m giving them 72 seconds to consider this amendment.

This amendment deals with some very complicated subjects; and it provides, of course, as we are not surprised that it has, for substantial billions of dollars back to the insurance companies. That’s what their objective is. And, yes, they say something about equity of distribution of money. No study.

We set up a very careful study to make sure that the people’s money is distributed to the States in an equitable, fair, effective fashion. That is why we ought to reject this amendment for which we received no notice, no consideration, no discussion in the public. The Republicans have arrogated about that.

I ask our party, I ask each one of us, to reject this motion to recommit and pass this bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit. The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BURTON of Indiana. Mr. Speaker, I demand a recorded vote.

A recorded vote was taken.

The vote was taken by electronic device, and there were—ayes 220, noes 215, not voting 0, as follows:

[Roll No. 887]
This is a 5-minute vote.

There are 2 minutes remaining in the rules of the House.

The Speaker pro tempore (Mr. Edwards of Texas). The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 895, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The Speaker pro tempore (Mr. Edwards of Texas). The question is on the motion offered by the gentleman from Missouri (Mr. Skelton) that the House suspend the rules and agree to the resolution, H. Res. 895. This is a 5-minute vote.