AMENDMENT NO. 2398

At the request of Mrs. CLINTON, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of amendment No. 2398 intended to be proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2400

At the request of Mr. NELSON of Florida, his name was withdrawn as a cosponsor of amendment No. 2400 intended to be proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2405

At the request of Mr. ALEXANDER, the name of the Senator from Arizona (Mr. KYL) was added as a cosponsor of amendment No. 2405 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2407

At the request of Mr. LIEBERMAN, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of amendment No. 2407 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2413

At the request of Mr. MARTINEZ, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of amendment No. 2413 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2416

At the request of Mr. SCHUMER, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of amendment No. 2416 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2417

At the request of Mrs. BOXER, her name was added as a cosponsor of amendment No. 2417 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

At the request of Mr. SALAZAR, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of amendment No. 2417 proposed to H.R. 2638, supra.

AMENDMENT NO. 2442

At the request of Mr. COBURN, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of amendment No. 2442 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Securityfor the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2464

At the request of Mr. OBAMA, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 2464 intended to be proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Securityfor the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2468

At the request of Ms. LANDRIEU, the names of the Senator from North Dakota (Mr. CONRAD) and the Senator from North Dakota (Mr. DORGAN) were added as cosponsors of amendment No. 2468 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Securityfor the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2473

At the request of Mr. OBAMA, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 2473 intended to be proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Securityfor the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 2476

At the request of Mr. GRASSLEY, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of amendment No. 2476 proposed to H.R. 2638, a bill making appropriations for the Department of Homeland Securityfor the fiscal year ending September 30, 2008, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HARKIN (for himself and Mr. SPECTER):

S. 1881. A bill to amend the Americans with Disabilities Act of 1990 to restore the intent and protections of that Act, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I am joining, today, with the senior Senator from Pennsylvania, Senator SPECTER, in introducing the ADA Restoration Act of 2007.

Today, July 26, marks the 17th anniversary of the signing of the Americans with Disabilities Act, one of the landmark civil rights laws of the 20th century, and a long-overdue emancipation proclamation for the 50 million Americans with disabilities.

As chief sponsor of the ADA in the Senate, I take pride in the progress we have made as a Nation since 1990. We have removed most physical barriers to movement and access for the 50 million Americans with disabilities. We have required employers to provide reasonable accommodations so that people with disabilities can have equal opportunity in the workplace. We have advanced the 4 goals of the ADA, equality of opportunity, full participation, independent living, and economic self-sufficiency.

So today is a day, first and foremost, to celebrate all that has been accomplished over the last 17 years.

But despite that progress, there is a problem. In recent years, the courts have ignored Congress's clear intent as to who should be protected under the ADA. And the courts have narrowed the definition of who qualifies as an ''individual with a disability.'' As a consequence, millions of people we intended to be protected under the ADA, including people with epilepsy, diabetes, and cancer, are not protected any more. In a ruling just this spring, the 11th Circuit court even concluded that a person with mental retardation was not ''disabled'' under the ADA.

Looking back through the legislative history, it is abundantly clear that Congress intended that the protections in the ADA apply to all persons without regard to mitigating circumstances, such as taking medication or using an assistive device.

In the Senate Labor and Human Resources Committee report Congress said:

> Whether a person has a disability should be assessed without regard to the availability of mitigating measures, such as reasonable accommodations or auxiliary aids.

The House Education and Labor Committee report says the same thing, and goes on to say:

> For example, a person who is hard of hearing is substantially limited in the major life activity of hearing, even though the loss may be corrected through the use of a hearing aid. Likewise, persons with impairments, such as epilepsy or diabetes, which substantially limit a major life activity are covered under . . . the definition of disability, even if the effects of the impairment are controlled by medication.

Nonetheless, in a series of cases, the Supreme Court ignored Congressional intent. Together, these Supreme Court cases have created an absurd and unintended Catch 22. People with serious health conditions like epilepsy or diabetes who are fortunate to find treatments that make them more capable and independent, and more able to work, may find that they are no longer protected by the ADA. If these individuals are no longer covered under the ADA, then their requests for a reasonable accommodation at work can be denied, or they can be fired. On the other hand, if they stop taking their medication, they will be considered a person with a disability under the ADA, but they will be unable to do their job.

This is not just absurd, it is wrong. It flies in the face of clear, unambiguous Congressional intent. When we passed the law, there was common agreement on both sides of the aisle, and on the part of the White House, that the law was designed to protect any individual who is treated less favorably because of a current, past, or perceived disability.

This situation cries out for a modest, reasonable legislative fix, and that is exactly what we are doing, today, by introducing the ADA Restoration Act of 2007.

Our bill amends the definition of ''disability'' so that people who Congress originally intended to be protected from discrimination are covered under the ADA.

Mr. Presdient, 17 years ago, the Americans with Disabilities Act passed with overwhelming bipartisan support. Likewise, today, we are building a strong bicameral, bipartisan majority to support ADA Restoration. A companion bill is being introduced, today, in the House.

As with the original passage of the ADA in 1990, it is going to take time to hold hearings and build strong majorities. But I look forward to working to restore Congress' original intent, and, once again, to ensure that Americans with disabilities are protected from discrimination.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was orderd to be printed in the RECORD, as follows:

S. 1881

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Americans with Disabilities Act Restoration Act of 2007''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) in enacting the Americans with Disabilities Act of 1990, Congress intended that the Act ''establish a clear and comprehensive prohibition of discrimination on the basis of disability'', and provide broad coverage and vigorous and effective remedies without unnecessary and obstructive defenses;

(2) decisions and opinions of the Supreme Court have unduly narrowed the broad scope of protection afforded by the Americans with Disabilities Act of 1990, eliminating protection for a broad range of individuals whom Congress intended to protect;

(3) in enacting the Americans with Disabilities Act of 1990, Congress recognized that physical and mental impairments are natural parts of the human experience that in no way diminish a person's right to fully participate in all aspects of society, but Congress also recognized that people with physical or mental impairments having the talent, skills, abilities, and desire to participate in society are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers;

(4)(A) Congress modeled the Americans with Disabilities Act of 1990 definition of disability on that of section 504 of the Rehabilitation Act of 1973 (referred to in this section as ''section 504''), which had, prior to the date of enactment of the Americans with Disabilities Act of 1990, been construed broadly to encompass both actual and perceived limitations, and limitations imposed by society; and

(B) the broad conception of the definition contained in section 504 had been underscored by the Supreme Court's statement in its decision in School Board of Nassau County v. Arline, 480 U.S. 273 (1987), that the definition ''acknowledged that society's myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment'';

(5) in adopting, in the Americans with Disabilities Act of 1990, the concept of disability expressed in section 504, Congress understood that adverse action based on a person's physical or mental impairment is often unrelated to the limitations caused by the impairment itself;

(6) instead of following congressional expectations that the term ''disability'' would be interpreted broadly in the Americans with Disabilities Act of 1990, the Supreme Court has ruled, in Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002), that the elements of the definition ''need to be interpreted strictly to create a demanding standard for qualifying as disabled'' and, consistent with that view, has narrowed the application of the definition in various ways; and

(7) contrary to explicit congressional intent expressed in the committee reports for the Americans with Disabilities Act of 1990, the Supreme Court has eliminated from the Act's coverage individuals who have mitigated the effects of their impairments through the use of such measures as medication and assistive devices.

(b) PURPOSE.—The purposes of this Act are—

(1) to effect the Americans with Disabilities Act of 1990's objectives of providing ''a clear and comprehensive national mandate for the elimination of discrimination'' and ''clear, strong, consistent, enforceable standards addressing discrimination'' by restoring the broad scope of protection available under the Americans with Disabilities Act of 1990;

(2) to respond to certain decisions of the Supreme Court, including Sutton v. United Air Lines, Inc., (527 U.S. 471 (1999), Murphy v. United Parcel Service, Inc., 527 U.S. 516 (1999), Albertson's, Inc. v. Kirkingburg, 527 U.S. 555 (1999), and Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002), that have narrowed the class of people who can invoke the protection from discrimination that the Americans with Disabilities Act of 1990 provides; and

(3) to reinstate the original congressional intent regarding the definition of disability in the Americans with Disabilities Act of 1990 by clarifying that the protection of that Act is available for all individuals who are—

(A) subjected to adverse treatment based on an actual or perceived impairment, or a record of impairment; or

(B) adversely affected—

(i) by prejudiced attitudes, such as myths, fears, ignorance, or stereotypes concerning disability or particular disabilities; or

(ii) by the failure to remove societal and institutional barriers, including communication, transportation, and architectural barriers, or the failure to provide reasonable modifications to policies, practices, and procedures, reasonable accommodations, and auxiliary aids and services.

SEC. 3. FINDINGS IN AMERICANS WITH DISABILITIES ACT OF 1990.

Section 2(a) of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101(a)) is amended—

(1) by striking paragraph (1) and inserting the following:

''(1)(A) physical and mental disabilities are natural parts of the human experience that in no way diminish a person's right to fully participate in all aspects of society; and

''(B)(i) people with physical or mental disabilities having the talent, skills, abilities, and desire to participate in society are frequently precluded from doing so because of discrimination; and

''(ii) other people who have a record of a disability or are regarded as having a disability have also been subjected to discrimination;''; and

(2) by striking paragraph (7) and inserting the following:

''(7)(A) individuals with disabilities have been subjected to a history of purposeful unequal treatment, have had restrictions and limitations imposed upon them because of their disabilities, and have been relegated to positions of political powerlessness in society; and

''(B) classifications and selection criteria that exclude individuals with disabilities should be strongly disfavored, subjected to skeptical and meticulous examination, and permitted only for highly compelling reasons, and never on the basis of prejudice, myths, irrational fears, ignorance, or stereotypes about disability;''.

SEC. 4. DISABILITY DEFINED.

Section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102) is amended—

(1) by striking paragraph (2) and inserting the following:

''(2) DISABILITY.—

''(A) IN GENERAL.—The term 'disability' means—

''(i) a physical or mental impairment;

''(ii) a record of a physical or mental impairment; or

''(iii) being regarded as having a physical or mental impairment.

''(B) RULE OF CONSTRUCTION.—

''(i) DETERMINATION OF IMPAIRMENT.—The determination of whether an individual has a physical or mental impairment shall be made without regard to—

''(I) whether the individual uses a mitigating measure;

''(II) the impact of any mitigating measures the individual may or may not be using;

''(III) whether any manifestation of the impairment is episodic; or

''(IV) whether the impairment is in remission or latent.

''(ii) MITIGATING MEASURES.—The term 'mitigating measure' means any treatment, medication, device, or other measure used to eliminate, mitigate, or compensate for the effect of an impairment, and includes prescription and other medications, personal aids and devices (including assistive technology devices and services), reasonable accommodations, and auxiliary aids and services.''; and

(2) by redesignating paragraph (3) as paragraph (7) and inserting after paragraph (2) the following:

''(3) MENTAL IMPAIRMENT.—The term 'mental', used with respect to an impairment, means any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disability.

''(4) PHYSICAL IMPAIRMENT.—The term 'physical', used with respect to an impairment, means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting 1 or more of the following body systems:

''(A) Neurological.

''(B) Musculoskeletal.

''(C) Special sense organs.

''(D) Respiratory, including speech organs.

''(E) Cardiovascular.

''(F) Reproductive.

''(G) Digestive.

''(H) Genitourinary.

''(I) Hemic and lymphatic.

''(J) Skin.

''(K) Endocrine.

''(5) RECORD OF A PHYSICAL OR MENTAL IMPAIRMENT.—The term 'record of a physical or mental impairment' means a history of, or a

misclassification as having, a physical or mental impairment.

''(6) REGARDED AS HAVING A PHYSICAL OR MENTAL IMPAIRMENT.—The term 'regarded as having a physical or mental impairment' means perceived or treated as having a physical or mental impairment, whether or not the individual involved has an impairment.''.

SEC. 5. ADVERSE ACTION.

The Americans with Disabilities Act of 1990 is amended by inserting after section 3 (42 U.S.C. 12102) the following:

''SEC. 4. ADVERSE ACTION.

''An adverse action taken by an entity covered under this Act against an individual because of that individual's use of a mitigating measure or because of a side effect or other consequence of the use of such a measure shall constitute discrimination under this Act.''.

SEC. 6. DISCRIMINATION ON THE BASIS OF DISABILITY.

Section 102 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12112) is amended—

(1) in subsection (a), by striking ''against a qualified individual with a disability because of the disability of such individual'' and inserting ''against an individual on the basis of disability''; and

(2) in subsection (b), in the matter preceding paragraph (1), by striking the term ''discriminate'' and inserting ''discriminate against an individual on the basis of disability''.

SEC. 7. QUALIFIED INDIVIDUAL.

Section 103(a) of the Americans with Disabilities Act of 1990 (42 U.S.C. 2113(a)) is amended by striking ''that an alleged'' and inserting ''that—

''(1) the individual alleging discrimination under this title is not a qualified individual with a disability; or

''(2) an alleged''.

SEC. 8. RULE OF CONSTRUCTION.

Section 501 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12201) is amended by adding at the end the following:

''(e) BROAD CONSTRUCTION.—In order to ensure that this Act achieves the purpose of providing a comprehensive prohibition of discrimination on the basis of disability and to advance the remedial purpose of this Act, the provisions of this Act shall be broadly construed.

''(f) REGULATIONS.—

''(1) IN GENERAL.—Not later than 180 days after the date of enactment of the Americans with Disabilities Act Restoration Act of 2007—

''(A) the Attorney General, the Equal Employment Opportunity Commission, and the Secretary of Transportation shall issue regulations described in sections 106, 204, 223, 229, 244, and 306, as appropriate, including regulations that implement sections 3 and 4, to carry out the corresponding provisions of this Act, as this Act is amended by the Americans with Disabilities Act Restoration Act of 2007; and

''(B) the Architectural and Transportation Barriers Compliance Board shall issue supplementary guidelines described in section 504, to supplement the existing Minimum Guidelines and Requirements for Accessible Design for purposes of titles II and III of this Act, as this Act is amended by the Americans with Disabilities Act Restoration Act of 2007.

''(2) CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of an officer or agency described in paragraph (1) to issue regulations or guidelines under any other provision of this Act, other than this subsection.

''(g) DEFERENCE TO REGULATIONS AND GUIDANCE.—Duly issued Federal regulations and guidance for the implementation of the Americans with Disabilities Act of 1990, including provisions implementing and interpreting the definition of disability, shall be entitled to deference by administrative agencies or officers, and courts, deciding an issue in any action brought under this Act.''.

By Mr. HAGEL (for himself, Mr. DURBIN, Mr. BIDEN, and Mrs. BOXER):

S. 1882. A bill to amend the Public Health Service Act to establish various programs for the recruitment and retention of public health workers and to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN. Mr. President, in the last few years, our Nation's public health has been threatened repeatedly. We have faced natural disasters like the horrific damage done by Hurricane Katrina. We have endured human-led catastrophes like the tragic September 11 attacks. Only a couple of months ago, a man infected with a potentially lethal strain of extremely drug-resistant tuberculosis was able to travel from his home in Atlanta to France, Greece, the Czech Republic, and Canada, before ending up at a center in Denver for treatment.

These emergencies have made it clear that our public health system must be prepared for the unexpected.

Our ability to prevent, respond to, and recover from incidents like these depends upon an adequately staffed and well trained public health workforce. But if we look at our public health workforce today, what we see is alarming: an aging staff nearing retirement with no clear pipeline of trained employees to fill the void.

The average age of lab technicians, epidemiologists, environmental health experts, microbiologists, IT specialists, administrators, and other public health workers is 47. That is 7 years older than the average age of the Nation's workforce. Retirement rates are as high as 20 percent in some State public health agencies. Nearly half of the Federal employees in positions critical to our biodefense will be eligible to retire by 2012. The average age of a public health nurse is near 50 years.

These statistics are sobering. As the responsibilities of our public health workforce are growing, their ranks continue to shrink. These are shortages that impact not just for the security of our health, but our national security.

We can't afford to overlook this problem any longer. For the third consecutive Congress, Senator HAGEL and I are introducing the Public Health Preparedness Workforce Development Act of 2007. This is a bill that will increase the pipeline of qualified public health workers at all levels—Federal, State, local, and tribal. It offers scholarships and loan repayment as recruitment and retention incentives for students who enter and stay in the field of public health. It also provides opportunities for mid-career public health professionals to go back for additional training in public health preparedness or biodefense.

The time to prepare for a public health emergency, whether that be a natural disaster or one of our own making, is not tomorrow, nor next month, nor a year from now, but today. Looking forward we must strengthen our public health workforce. I urge my colleagues to join me and the Senator from Nebraska in taking up and passing the Public Health Preparedness Workforce Development Act. We must all make a commitment to securing the safety of our nation, and that security begins with our public health.

By Mr. KOHL (for himself, Mr. DORGAN, and Mr. WYDEN):

S. 1883. A bill to amend title XVIII of the Social Security Act to provide for standardized marketing requirements under the Medicare Advantage program and the Medicare prescription drug program and to provide for State certification prior to waiver of licensure requirements under the Medicare prescription drug program, and for other purposes; to the Committee on Finance.

Mr. KOHL. Mr. President, I rise today to introduce the Accountability and Transparency in Medicare Marketing Act, on behalf of myself and Senator DORGAN and WYDEN. This legislation aims to regulate the marketing standards and sales tactics of Medicare Advantage and Medicare prescription drug plans, now the fastest growing segment of Medicare and a prime target for fraud, misrepresentation, and deceptive sales practices.

As chairman of the Special Committee on Aging, I recently held a hearing entitled, ''Medicare Advantage Marketing and Sales: Who Has the Advantage?'' Our hearing uncovered that a large majority of State insurance departments have received, and continue to receive, an unprecedented number of complaints about inappropriate or confusing marketing practices that have led Medicare beneficiaries to enroll in Medicare Advantage plans without adequately understanding the consequences of their decisions.

My legislation will facilitate the creation of uniform marketing standards that will be adopted and enforced by individual states. Based on current law, CMS has exclusive authority to investigate and discipline the marketing and selling of Medicare advantage products, while States have only been permitted to examine and enforce violations against individual insurance agents. This unusual arrangement, which some might call a pre-emption of authority, has left a sizable enforcement gap that has exacerbated the problems found by the committee.

This legislation will close that gap, giving States the ability to standardize marketing and sales regulations, as well as regulate both agents and companies in the marketing and sales of

Medicare Advantage and prescription drug plans. Ultimately, State insurance commissioners will have the ability to work in conjunction with CMS in order to provide the most comprehensive protection possible for Medicare beneficiaries.

Senior citizens deserve to have access to the health care plan that best serves their needs without having to worry about being purposely mislead and deceived. I believe we must repair this disconnect in oversight and ensure the protection of American seniors, and I hope my colleagues will join in my effort to do so.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be placed in the RECORD, as follows:

S. 1883

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Accountability and Transparency in Medicare Marketing Act of 2007''.

SEC. 2. STANDARDIZED MARKETING REQUIREMENTS UNDER THE MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG PROGRAMS.

(a) MEDICARE ADVANTAGE PROGRAM.—

(1) IN GENERAL.—Section 1856 of the Social Security Act (42 U.S.C. 1395w–26) is amended—

(A) in subsection (b)(1), by inserting ''or subsection (c)'' after ''subsection (a)''; and

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

''(c) STANDARDIZED MARKETING REQUIREMENTS.—

''(1) DEVELOPMENT BY THE NAIC.—

''(A) REQUIREMENTS.—The Secretary shall request the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') to—

''(i) develop standardized marketing requirements for Medicare Advantage organizations with respect to Medicare Advantage plans and PDP sponsors with respect to prescription drug plans under part D; and

''(ii) submit a report containing such requirements to the Secretary by not later than the date that is 9 months after the date of enactment of this subsection.

''(B) PROHIBITED ACTIVITIES.—Such requirements shall prohibit the following:

''(i) Cross-selling of non-Medicare products or services with products or services offered by a Medicare Advantage plan or a prescription drug plan under part D.

''(ii) Up-selling from prescription drug plans under part D to Medicare Advantage plans.

''(iii) Telemarketing (including cold calling) conducted by an organization with respect to a Medicare Advantage plan or a PDP sponsor with respect to a prescription drug plan under part D (or by an agent of such an organization or sponsor).

''(iv) A Medicare Advantage organization or a PDP sponsor providing cash or other monetary rebates as an inducement for enrollment or otherwise.

''(C) ELECTION FORM.—Such requirements may prohibit a Medicare Advantage organization or a PDP sponsor (or an agent of such an organization or sponsor) from completing any portion of any election form used to carry out elections under section 1851 or 1860D–1 on behalf of any individual.

''(D) AGENT AND BROKER COMMISSIONS.—Such requirements shall establish standards—

''(i) for fair and appropriate commissions for agents and brokers of Medicare Advantage organizations and PDP sponsors, including a prohibition on extra bonuses or incentives; and

''(ii) for the disclosure of such commissions.

''(E) CERTAIN CONDUCT OF AGENTS.—Such requirements shall address the conduct of agents engaged in on-site promotion at a facility of an organization with which the Medicare Advantage organization or PDP sponsor has a cobranding relationship.

''(F) OTHER STANDARDS.—Such requirements may establish such other standards relating to marketing under Medicare Advantage plans and prescription drug plans under part D as the NAIC determines appropriate.

''(2) IMPLEMENTATION OF REQUIREMENTS.—

''(A) ADOPTION OF NAIC DEVELOPED REQUIREMENTS.—If the NAIC develops standardized marketing requirements and submits the report pursuant to paragraph (1), the Secretary shall promulgate regulations for the adoption of such requirements. The Secretary shall ensure that such regulations take effect not later than the date that is 10 months after the date of enactment of this subsection.

''(B) REQUIREMENTS IF NAIC DOES NOT SUBMIT REPORT.—If the NAIC does not develop standardized marketing requirements and submit the report pursuant to paragraph (1), the Secretary shall promulgate regulations for standardized marketing requirements for Medicare Advantage organizations with respect to Medicare Advantage plans and PDP sponsors with respect to prescription drug plans under part D. Such regulations shall prohibit the conduct described in paragraph (1)(B), may prohibit the conduct described in paragraph (1)(C), shall establish the standards described in paragraph (1)(D), shall address the conduct described in paragraph (1)(E), and may establish such other standards relating to marketing under Medicare Advantage plans and prescription drug plans as the Secretary determines appropriate. The Secretary shall ensure that such regulations take effect not later than the date that is 10 months after the date of enactment of this subsection.

''(C) CONSULTATION.—In establishing requirements under this subsection, the NAIC or Secretary (as the case may be) shall consult with a working group composed of representatives of Medicare Advantage organizations and PDP sponsors, consumer groups, and other qualified individuals. Such representatives shall be selected in a manner so as to insure balanced representation among the interested groups.

''(3) STATE REPORTING OF VIOLATIONS OF STANDARDIZED MARKETING REQUIREMENTS.—The Secretary shall request that States report any violations of the standardized marketing requirements under the regulations under subparagraph (A) or (B) of paragraph (2) to national and regional offices of the Centers for Medicare & Medicaid Services.

''(4) REPORT.—The Secretary shall submit an annual report to Congress on the enforcement of the standardized marketing requirements under the regulations under subparagraph (A) or (B) of paragraph (2), together with such recommendations as the Secretary determines appropriate. Such report shall include—

''(A) a list of any alleged violations of such requirements reported to the Secretary by a State, a Medicare Advantage organization, or a PDP sponsor; and

''(B) the disposition of such reported violations.''.

(2) STATE AUTHORITY TO ENFORCE STANDARDIZED MARKETING REQUIREMENTS.—

(A) IN GENERAL.—Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended—

(i) by striking ''or State'' and inserting '', State''; and

(ii) by inserting '', or State laws or regulations enacting the standardized marketing requirements under subsection (c)'' after ''plan solvency''.

(B) NO PREEMPTION OF STATE SANCTIONS.—Nothing in title XVIII of the Social Security Act or the provisions of, or amendments made by, this Act, shall be construed to prohibit a State from imposing sanctions against Medicare Advantage organizations, PDP sponsors, or agents or brokers of such organizations or sponsors for violations of the standardized marketing requirements under subsection (c) of section 1856 of the Social Security Act (as added by paragraph (1)) as enacted by that State.

(3) CONFORMING AMENDMENT.—Section 1851(h)(4) of the Social Security Act (42 U.S.C. 1395w–21(h)(4)) is amended by adding at the end the following flush sentence:

''Beginning on the effective date of the implementation of the regulations under subparagraph (A) or (B) of section 1856(c)(2), each Medicare Advantage organization with respect to a Medicare Advantage plan offered by the organization (and agents of such organization) shall comply with the standardized marketing requirements under section 1856(c).''.

(b) MEDICARE PRESCRIPTION DRUG PROGRAM.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(l) STANDARDIZED MARKETING REQUIREMENTS.—A PDP sponsor with respect to a prescription drug plan offered by the sponsor (and agents of such sponsor) shall comply with the standardized marketing requirements under section 1856(c).''.

SEC. 3. STATE CERTIFICATION PRIOR TO WAIVER OF LICENSURE REQUIREMENTS UNDER MEDICARE PRESCRIPTION DRUG PROGRAM.

(a) IN GENERAL.—Section 1860D–12(c) of the Social Security Act (42 U.S.C. 1395w–112(c)) is amended—

(1) in paragraph (1)(A), by striking ''In the case'' and inserting ''Subject to paragraph (5), in the case''; and

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

''(5) STATE CERTIFICATION REQUIRED.—

''(A) IN GENERAL.—The Secretary may only grant a waiver under paragraph (1)(A) if the Secretary has received a certification from the State insurance commissioner that the prescription drug plan has a substantially complete application pending in the State.

''(B) REVOCATION OF WAIVER UPON FINDING OF FRAUD AND ABUSE.—The Secretary shall revoke a waiver granted under paragraph (1)(A) if the State insurance commissioner submits a certification to the Secretary that the recipient of such a waiver—

''(i) has committed fraud or abuse with respect to such waiver;

''(ii) has failed to make a good faith effort to satisfy State licensing requirements; or

''(iii) was determined ineligible for licensure by the State.''.

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to plan years beginning on or after January 1, 2008.

SEC. 4. NAIC RECOMMENDATIONS ON THE ESTABLISHMENT OF STANDARDIZED BENEFIT PACKAGES FOR MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health

and Human Services shall request the National Association of Insurance Commissioners to establish a committee to study and make recommendations to the Secretary and Congress on—

(1) the establishment of standardized benefit packages for Medicare Advantage plans under part C of title XVIII of the Social Security Act and for prescription drug plans under part D of such Act; and

(2) the regulation of such plans.

By Mr. SALAZAR:

S. 1884. A bill to amend the Farm Security and Rural Investment Act of 2002 to reauthorize and improve agricultural energy programs, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry,

Mr. SALAZAR. Mr. President, today I am introducing a bill that will help deliver clean energy technologies from the research pipelines of our labs into the hands of our farmers and ranchers, so that we can take better advantage of our farms and fields for clean energy production. This bill, called the Harvesting Energy Act, will bolster the energy title of this year's farm bill, building on the good ideas that Chairman HARKIN, Ranking Member CHAMBLISS, and the rest of us on the Agriculture Committee have been working on for several months.

I am proud that the Harvesting Energy Act reflects the broad-based, bipartisan input of the 25 by '25 coalition which, earlier this year, provided us with their policy recommendations for how we can produce 25 percent of our energy from renewable resources by 2025. The 25 by '25 vision has been endorsed by 22 current and former Governors and several State legislatures across the country, along with over 500 organizations and companies, including the Big Three automobile manufacturers, agricultural producers, and environmental groups. We established 25 by '25 as a national goal earlier this year when we passed the Energy bill in the Senate. We must now implement the policies that are necessary to achieve that goal.

I have spoken many times about the urgency of moving this Nation toward energy independence by making better use of the resources we have here at home. Responsible development of our oil and gas resources, improved efficiency and conservation, and more aggressive investment in renewable energy technologies—these are the three pillars upon which we must build an economy that is less dependent on foreign oil.

I do not need to remind my colleagues of the dangers that oil dependence poses to the United States and to global security. It is oil that empowers states such as lran, Venezuela, and Syria. It is oil that contributes to violence in Iraq, Nigeria, and the Sudan. It is oil that places Russia and China in a dangerous competition for oil in Central Asia and Africa.

This Congress has made remarkable progress since January in confronting the daunting task of reducing our dependence on foreign oil. It is an effort that has spanned several committees.

The Energy bill that we passed in early June represented the diligent work of the Energy and Natural Resources Committee, the Commerce Committee, and the Finance Committee. I was proud of the work we did on that bill, from creating meaningful oil savings targets to making smarter investments in renewables, improving vehicle standards, and establishing a national goal of producing 25 percent of our energy from our farms and fields by 2025.

I am also proud of the energy work we are doing on the farm bill in the Agriculture Committee. Thanks to Chairman HARKIN's leadership, the 2007 farm bill will build on the 2002 farm bill's first-ever energy title.

This is an important step that recognizes the central role that our farmers and ranchers must play in a new, clean energy economy. We have the most productive lands and most efficient farmers in the world, allowing America to be the breadbasket for the global community. With these resources, talent, and ingenuity, there is no doubt that we can grow our way to energy independence.

As I travel through Colorado, the possibilities of a clean energy revolution, driven by farmers and ranchers, are clear.

In Weld County, Logan County, and Yuma County, we are seeing biofuel plants spring to life, creating new markets and new opportunities for our rural communities. In 2004, there were no ethanol plants in Colorado. Today, three plants produce more than 90 million gallons per year, and a fourth plant will come on line later this year, adding another 50 million gallons per year.

But it is not just biofuels. In the San Luis Valley, where my family has lived for five generations, Xcel Energy just broke ground on the largest solar plant in North America.

We have added 60 megawatts of wind capacity in Colorado in the last 2 years, and by the end of 2007, we will add another 775 megawatts, more than tripling the State's production of wind power to more than 1,000 megawatts. This is good for households along the Front Range that get clean, affordable power, and it is good for the ranchers in Prowers County, who own the land on which the turbines sit.

These biofuel plants, wind turbines, and solar farms are revitalizing rural communities that have been withering on the vine. They are bringing life back to main streets that were boarded up and excitement back to farmers and ranchers who are eager to be a part of our clean energy revolution.

The bill I am introducing today will help stimulate this revolution by getting more renewable energy technologies out of the development pipeline and into the fields, where they belong.

It is based on the recommendations contained in the 25 by 25 Action Plan and builds on those ideas with important new initiatives to supplement the energy title of the farm bill. Our goal is to ensure that the renewable energy work being done at the Department of Energy and in colleges and universities throughout the country, in which we invested earlier this year through the Energy bill, is accompanied by a strong commitment at USDA to bring the resulting technologies and methods out to farmers and ranchers.

USDA has a long history of identifying promising new production methods and technologies, refining them, and making them available to agricultural producers. The Akron Research Station in Washington County, CO, is a great example. For 100 years it has connected our farmers in eastern Colorado with the latest practical agricultural research available.

USDA can and should be making the same efforts to disperse the latest and best developments from the renewable energy revolution to farmers and ranchers.

I want to briefly describe four ways in which my bill will bolster USDA's capabilities in this area and help make the 25x'25 vision a reality.

First, the Harvesting Energy Act of expands and extends Section 9006 of the farm bill, which offers competitive grants and loan guarantees to help farmers, ranchers, and rural small businesses invest in proven clean energy technologies. My bill adds $280 million to section 9006, following the recommendations of the 25x'25 Agriculture Energy Alliance. This will ramp up the loan guarantees for cellulosic ethanol facilities, encourage community wind and other electric power projects, and expand the number of eligible applicants for these loans and grants. This is a responsible way to help more farmers become net energy producers of on-farm renewable energy.

Second, my bill accelerates research, development, demonstration, and deployment of renewable resources such as biomass, wind, solar, and renewable natural gas. I am proposing that we devote an additional $200 million per year to these efforts, with the specific goals of bringing biomass energy feedstocks such as native grasses and short-rotation trees into production; perfecting our biorefinery and conversion technologies; refining biofuels from these biomass feedstocks; and making use of the biobased coproducts to add value to the process.

Third, if we are to continue to expand biofuels production, we need to ensure that the supply is stable so that we don't encounter major shortages in droughts or in periods of adverse weather. Storing feedstocks like corn, oilseed crops, and biomass for cellulosic ethanol will better protect consumers from huge price fluctuations or shortages. My bill would create a voluntary biofuel feedstock reserve that would encourage farmers to store these feedstocks on-farm and make them available for biofuel production when a price spike or a shortage occurs.

Fourth, the Harvesting Energy Act invests in research and development in new production technologies that promise to yield high energy returns and carbon storage. One of the key investments that this bill makes is in biochar. Biochar is a type of charcoal produced from biomass that is valuable as a soil amendment. The USDA and DOE are finding that they can produce biochar as a carbon-capturing byproduct of cellulosic ethanol production. This is good for farmers, who put the biochar back into the soil as a fertilizer, good for the environment because it reduces carbon emissions, and good for consumers because it could drive down cellulosic ethanol production costs. My bill would provide $50 million in competitive funding for research and development grants to scale-up and commercialize biochar production systems. Like so much else we are doing in the energy title of the farm bill, this would move ideas from the research pipeline out into the field, where they need to be.

This bill includes a wide range of other provisions that build on the good work that the Agriculture Committee is doing on the farm bill. Like the provisions I have described, they aim to expand the menu of renewable energy options we have available as we work to reduce our dependence on foreign oil.

I again thank Chairman HARKIN and Senator CHAMBLISS for their leadership on the Agriculture Committee and for their commitment to creating a robust energy title in this year's farm bill. I firmly believe that with the right investments and a commitment from this Congress, our farmers and ranchers can help lead us down the path to energy independence.

By Mr. SMITH (for himself and Mr. KERRY):

S. 1887. A bill to amend title XVIII of the Social Security Act in order to ensure access to critical medications under the Medicare Part D prescription drug program; to the Committee on Finance.

Mr. Smith. Mr. President, today I am introducing the Access to Critical Medications Act ACMA, a bill that will vastly improve the coverage millions of vulnerable Medicare beneficiaries receive through the Medicare prescription drug program, known as Part D. The new drug benefit has been a tremendous success, providing access to affordable prescription drug therapies to millions of beneficiaries, some for the very first time. But many of our most vulnerable seniors, especially those suffering from serious health conditions like mental illness, HIV/AIDS or cancer, often have difficulty obtaining the vital drug therapies they need to remain functional, or in some cases, to survive. To remedy these problems, the bill I am introducing today will give the Centers for Medicare and Medicaid Services, CMS, the regulatory tools it needs to ensure that all prescription drug plans, PDP, provide unfettered access to medically essential drug therapies.

My connection to this issue began long before Medicare's new prescription drug benefit went into effect. As chairman of the Aging Committee, I held a hearing in the spring of 2005 to explore how well CMS was preparing to transition dual-eligible beneficiaries, those who qualify for both Medicare and Medicaid, into Medicare Part D. At that hearing, advocates expressed a number of concerns with the implementation of the new drug benefit, and chief among them was guaranteeing that vulnerable beneficiaries had access to important drug therapies that either stabilized or improved their health condition. I made a personal request to then CMS Administrator Dr. Mark McClellan to work with prescription drug plans to ensure that their formularies provide access to all available drugs in certain pharmaceutical classes, including those that contain innovative treatments for mental illness, epilepsy, cancer and HIV/AIDS. The result of that conversation was the creation of the ''all or substantially all'' policy for six protected drug classes. CMS initially included this new policy as part of the sub-regulatory formulary guidance it issued to plans in 2005 and again in 2006.

While I was pleased with CMS providing this additional protection for the vital drug therapies in the six protected classes, its actual impact on beneficiaries gaining access to the medications they need has been uneven at best. For one, the policy was issued as sub-regulatory guidance, which limits CMS' ability to enforce it. While it is true that the annual contracts CMS develops with prescription drug plans generally include a requirement that they abide by the ''all or substantially all'' guidance, the agency's record of enforcing the policy has been quite poor. Instead of plans covering all drugs in the six protected classes, as CMS claims plan contracts require, beneficiaries, often the most frail and vulnerable, have had extensive access problems because their PDPs do not include their medication on its formulary. In fact, data from a study being conducted by the American Psychiatric Institute for Research and Education, APIRE, released earlier this year, showed that roughly 68 percent of surveyed beneficiaries, many of them dual eligibles, experienced some sort of problem accessing the prescription drug they needed because their PDP's formulary did not cover it. This would suggest that CMS' current approach to enforcing the ''all or substantially all'' policy is woefully lacking.

I should note that beneficiaries often are able to access a drug that should be covered on their plan's formulary by filing a coverage appeal. However, that process is usually long and difficult to complete, and results in the problem only being solved for one beneficiary. I appreciate the responsiveness of drug plans to specific beneficiaries' difficulties with accessing the drugs they need, but if they are not addressing the concerns raised through the appeals process on a broader scale, problems will only continue to occur. I believe we need a system-wide approach to ensuring that beneficiaries have access to the life-saving and life-improving medications they need and I believe that solution lies within the legislation I am filing today.

The Access to Critical Medications Act ACMA would codify, for a 5-year period, the current policies in CMS existing ''all or substantially all'' subregulatory guidance. I am hopeful that providing this statutory authority will signal to plans that it is no longer an option to cover all available drugs in the six protected classes. It is a legal requirement that must be adhered to in order to participate in Medicare Part D. Accordingly, I would expect that this change will empower CMS to take a more proactive role in ensuring that prescription drug plan sponsors are not placing arbitrary barriers to accessing these critical medications covered by the ''all or substantially all'' policy.

During the 5 year period that the ''all or substantially all'' policy will be effective, the ACMA directs CMS to establish a process through regulation, that would allow for this important policy to be updated and enforced in future years. None of us hold the knowledge of the pharmaceutical and medical developments of tomorrow. In a decade, there could be major breakthroughs in treating any number of debilitating illnesses, which may require the creation of or modification of pharmaceutical classes covered by this important policy. CMS needs to have the authority to update the classes and categories it covers and the process the ACMA creates will provide them the tools to do that.

In order to use those tools, the ACMA defines specific, clinically-based criteria that the Secretary must follow when evaluating whether a drug class should be added or removed from coverage under the policy. This will ensure that there is consistency in the manner by which the policy is evaluated in future years, so that the Secretary is not arbitrarily determining which medications are important enough so that all plans must provide access to them. The ACMA also makes modest changes to the appeals process, to ensure that plans and CMS resolve beneficiary complaints in a timely manner, and that access to medications is guaranteed while the appeals process runs its course.

The existing ''all or substantially all'' policy was a step in the right direction at the time it was created. However, as we approach the third year of Medicare's prescription drug benefit, beneficiaries' actual experience in the program provides overwhelming support that we need a more robust approach to helping vulnerable beneficiaries get the medications they need.

As importantly, CMS must have a regulatory process in place that will enable it to modify the classes covered by the policy in response to changes in medical and pharmaceutical science. I believe the ACMA clearly addresses both those needs, and I hope my colleagues will agree. It is a well thought out policy that strikes a careful balance between flexibility and enforceability. Advocacy groups such as the American Psychiatric Association, the National Alliance for Mental Illness, Mental Health America, the AIDS Institute, the HIV Medicine Association and the Epilepsy Foundation all contributed to the development of ACMA and all now support the finished product. The Senate likely will consider Medicare legislation this fall, and I have already mentioned to Chairman BAUCUS that I would like to see this bill advance as part of that effort.

I ask unanimous consent that the text of therbill and letters of support be printed in the RECORD.

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

S. 1887

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Access to Critical Medications Act of 2007''.

SEC. 2. FORMULARY REQUIREMENTS WITH RESPECT TO CERTAIN CATEGORIES AND CLASSES OF DRUGS.

(a) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

(1) INITIAL LIST.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended—

(A) in subparagraph (C)(i), by striking ''The formulary'' and inserting ''Subject to subparagraph (G), the formulary''; and

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

''(G) INITIAL LIST OF REQUIRED DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(i) IN GENERAL.—Subject to clause (iv), the formulary must include all or substantially all drugs in the following categories and classes that are available as of April 30 of the year prior to the year which includes the date of enactment of the Medicare Access to Critical Medications Act of 2007:

''(I) Immunosuppressant.

''(II) Antidepressant.

''(III) Antipsychotic.

''(IV) Anticonvulsant.

''(V) Antiretroviral.

''(VI) Antineoplastic.

''(ii) NEWLY APPROVED DRUGS.—

''(I) IN GENERAL.—In the case of a drug in any of the categories and classes described in subclauses (I) through (VI) of clause (i) that becomes available after the April 30 date described in clause (i), the formulary shall include such drug within 30 days of the drug becoming available, except that, in the case of such a drug that becomes available during the period beginning on such April 30 and ending on the date of enactment of the Medicare Access to Critical Medications Act of 2007, the formulary shall include such drug within 30 days of such date of enactment.

''(II) USE OF FORMULARY MANAGEMENT PRACTICES AND POLICIES.—Nothing in this clause shall be construed as preventing the Pharmacy and Therapeutic Committee of a PDP sponsor from advising such sponsor on the clinical appropriateness of utilizing formulary management practices and policies with respect to a newly approved drug that is required to be included on the formulary under subclause (I).

''(iii) UNIQUE DOSAGES AND FORMS.—A PDP sponsor of a prescription drug plan shall include coverage of all unique dosages and forms of drugs required to be included on the formulary pursuant to clause (i) or (ii).

''(iv) SUNSET.—The provisions of this subparagraph shall not apply after December 31 of the year which includes the date that is 5 years after the date of enactment of the Medicare Access to Critical Medications Act of 2007.''

(2) REVIEW OF DRUGS COVERED UNDER THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)), as amended by paragraph (1), is amended—

(A) in subparagraph (C)(i), by striking ''subparagraph (G)'' and inserting ''subparagraphs (G) and (H)''; and

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

''(H) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(i) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(I) IN GENERAL.—Beginning January 1 of the year after the year which includes the date that is 5 years after the date of enactment of the Medicare Access to Critical Medications Act of 2007, PDP sponsors offering prescription drug plans shall be required to include all unique dosages and forms of all or substantially all drugs in certain categories and classes, including the categories and classes described in subclauses (I) through (VI) of subparagraph (G)(i), on the formulary of such plans within 30 days of the drug becoming available.

''(II) REGULATIONS.—Not later than January 1 of the year after the year which includes the date that is 4 years after the date of enactment of the Medicare Access to Critical Medications Act of 2007, the Secretary shall issue regulations to carry out this clause.

''(ii) PERIODIC REVIEW.—The Secretary shall establish procedures to provide for periodic review of the drugs required to be included on the formulary under clause (i).

''(iii) UPDATING.—

''(I) IN GENERAL.—The Secretary may update the list of drugs required to be included on the formulary under clause (i) if the Secretary determines, in accordance with this clause, that updating such list is appropriate.

''(II) ADDING CATEGORIES OR CLASSES.—In issuing the regulations under clause (i) and updating the list in order to add a drug in a category or class to the list of drugs required to be included on the formulary under such clause, the Secretary shall consider factors that justify requiring coverage of drugs in a certain category or class, including the following:

''(aa) Whether the drugs in a category or class are used to treat a disease or disorder that can cause significant negative clinical outcomes to individuals in a short timeframe.

''(bb) Whether there are special or unique benefits with respect to the majority of drugs in a given category or class.

''(cc) High predicted drug and medical costs for the diseases or disorders treated by the drugs in a given category or class.

''(dd) Whether restricted access to the drugs in the category or class has major clinical consequences for individuals enrolled in a prescription drug plan who have a disease or disorder treated by the drugs in such category or class.

''(ee) The potential for the development of discriminatory formulary policies based on the clinical or functional characteristics of such individuals and the high cost of certain drugs in a category or class.

''(ff) The need for access to multiple drugs within a category or class due to the unique chemical action and pharmacological effects of drugs within the category or class and any variation in clinical response based on differences in such individuals' metabolism, age, gender, ethnicity, comorbidities, drug-resistance, and severity of disease.

''(gg) Any applicable revisions that have been made to widely-accepted clinical practice guidelines endorsed by pertinent medical specialty organizations.

''(III) REMOVAL OF CATEGORIES OR CLASSES.—In updating the list in order to remove a drug in a category or class from the list of drugs required to be included on the formulary under clause (i), the Secretary may remove a drug from such list in the case where the Secretary determines that widely-accepted clinical practice guidelines endorsed by pertinent national medical specialty organizations indicate that, for substantially all drugs in the category or class, restricting access to such drugs is unlikely to result in adverse clinical consequences for individuals with conditions for which the drugs are clinically indicated.''.

(b) LIMITATION OF UTILIZATION MANAGEMENT TOOLS FOR DRUGS IN CERTAIN CATEGORIES AND CLASSES.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended—

(1) in paragraph (1)(A), by striking ''A cost-effective'' and inserting ''Subject to paragraph (3), a cost-effective''; and

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

''(3) LIMITATION OF UTILIZATION MANAGEMENT TOOLS FOR DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—A PDP sponsor of a prescription drug plan may not apply a utilization management tool, such as prior authorization or step therapy, to the following:

''(i) During the period beginning on the date of enactment of this paragraph and ending on December 31 of the year which includes the date that is 5 years after such date of enactment—

''(I) a drug in a category or class described in subsection (b)(3)(G)(i)(V); and

''(II) a drug in a category or class described in subclause (I), (II), (III), (IV), or (VI) of subsection (b)(3)(G)(i) in the case where an enrollee was engaged in a treatment regimen using such drug in the 90-day period prior to the date on which such tool would be applied to the drug with respect to the enrollee under the plan or the PDP sponsor is unable to determine if the enrollee was engaged in such a treatment regimen prior to such date.

''(ii) Beginning January 1 of the year after the year which includes the date that is 5 years after the date of enactment of this paragraph—

''(I) a drug in a category or class described in subsection (b)(3)(G)(i)(V), if such drug is required to be included on the formulary under subsection (b)(3)(H); and

''(II) a drug in any other category or class required to be included on the formulary under subsection (b)(3)(H) in the case where an enrollee was engaged in a treatment regimen using such drug in the 90-day period prior to the date on which such tool would be applied to the drug with respect to the enrollee under the plan or the PDP sponsor is unable to determine if the enrollee was engaged in such a treatment regimen prior to such date

''(B) STATEMENT OF EVIDENCE BASE FOR APPLICATION OF UTILIZATION MANAGEMENT

TOOL.—In the case where a utilization management tool is applied to a drug in a category or class required to be included on a plan formulary under subparagraph (G) or (H) of subsection (b)(3), the PDP sponsor of such plan shall provide a statement of the evidence base substantiating the clinical appropriateness of the application of such tool.''.

(c) RULE OF CONSTRUCTION.—Nothing in the provisions of this section, or the amendments made by this section, shall be construed as prohibiting the Secretary of Health and Human Services from issuing guidance or regulations to establish formulary or utilization management requirements under section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) as long as they do not conflict with such provisions and amendments.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 2008.

SEC. 3. APPEALS REQUIREMENTS FOR CERTAIN CATEGORIES AND CLASSES OF DRUGS.

(a) COVERAGE DETERMINATIONS AND RECONSIDERATION.—Section 1860D–4(g) of the Social Security Act (42 U.S.C. 1395w–104(g)) is amended by adding at the end the following new paragraph:

''(3) REQUEST FOR A DETERMINATION OR RECONSIDERATION FOR THE TREATMENT OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—In the case where an individual enrolled in a prescription drug plan disputes a utilization management requirement, an adverse coverage determination, a reconsideration by a PDP sponsor of a prescription drug plan, or an adverse reconsideration by an Independent Review Entity with respect to a covered part D drug in the categories and classes required to be included on the formulary under subparagraph (G) of subsection (b)(3) or under the regulations issued under subparagraph (H) of such subsection, the PDP sponsor shall continue to cover such prescription drug until the date that is not less that 60 days after the latest of the following has occurred:

''(i) The enrollee has received written notice of an adverse reconsideration by a PDP sponsor.

''(ii) In the case where an enrollee has requested reconsideration by an Independent Review Entity, such Entity has issued an adverse reconsideration.

''(iii) In the case where an appeal of such adverse reconsideration has been filed by the individual, an administrative law judge has decided or dismissed the appeal.

''(B) DEFINITION OF INDEPENDENT REVIEW ENTITY.—In this paragraph, the term 'Independent Review Entity' means the independent, outside entity the Secretary contracts with under section 1852(g)(4), including such an entity that the Secretary contracts with in order to meet the requirements of such section under section 1860D–4(h)(1).''.

(b) APPEALS.—Section 1860D–4(h) of the Social Security Act (42 U.S.C. 1395w–104(h)) is amended—

(1) in paragraph (2), by striking ''A part D'' and inserting ''Subject to paragraph (4), a part D''; and

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

''(4) TREATMENT OF APPEALS FOR DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination by such sponsor not to provide coverage of a covered part D drug in a category or class required to be included on the formulary under subparagraph (G) of subsection (b)(3) or under the regulations issued under subparagraph (H) of such subsection at any time after such determination by requesting a reconsideration by an Independent Review Entity.

''(B) DEFINITION OF INDEPENDENT REVIEW ENTITY.—In this paragraph, the term 'Independent Review Entity' has the meaning given such term in subsection (g)(3)(B).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 2008.

SEC. 4. DATA REPORTING REQUIREMENTS FOR CERTAIN CATEGORIES AND CLASSES OF DRUGS UNDER THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM.

(a) IN GENERAL.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection

''(l) DATA REPORTING FOR CERTAIN CATEGORIES AND CLASSES OF DRUGS.—

''(1) IN GENERAL.—A PDP sponsor offering a prescription drug plan shall disclose to the Secretary (in a manner specified by the Secretary) data at the plan level on the number of—

''(A) favorable and adverse decisions made with respect to exceptions requested to formulary policies—

''(i) during the period beginning on the date of enactment of this subsection and ending on December 31 of the year which includes the date that is 5 years after such date of enactment, for each of the categories and classes of drugs described in subclauses (I) through (VI) of subsection (b)(3)(G)(i); and

''(ii) beginning January 1 of the year after the year which includes the date that is 5 years after such date of enactment, for each of the categories and classes of drugs required to be included on the formulary under the regulations issued under subsection (b)(3)(H);

''(B) favorable and adverse coverage determinations made with respect to each of such categories and classes during the applicable period;

''(C) favorable and adverse reconsiderations made by a PDP sponsor with respect to each of such categories and classes during the applicable period;

''(D) favorable and adverse reconsiderations made by an Independent Review Entity (as defined in subsection (g)(3)(B)) with respect to each of such categories and classes during the applicable period; and

''(E) appeals made to an administrative law judge and the decisions made on such appeals with respect to each of such categories and classes during the applicable period.

''(2) ANNUAL REPORT.—The Secretary shall—

''(A) submit an annual report to Congress containing the data disclosed to the Secretary under paragraph (1); and

''(B) publish such report in the Federal Register.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 2008.

ACCESS TO CRITICAL MEDICATIONS COALITION,
July 20, 2007.

Hon. GORDON SMITH,
404 Russell Office Building,
Washington, DC.

DEAR SENATOR SMITH: We are writing on behalf of the Access to Critical Medications Coalition to offer our strong support for your Medicare Access to Critical Medications Act. The Coalition represents a diverse group of national and community-based patient, provider and advocacy organizations dedicated to ensuring that Medicare beneficiaries with HIV/AIDS, mental illnesses, epilepsy, cancer, organ failure, and autoimmune diseases have reliable access through Medicare Part D to the prescriptions that they need to stay healthy.

The Medicare Access to Critical Medications Act will strengthen protections for these medically vulnerable populations by codifying the requirement that Medicare Part D plans cover ''all or substantially all'' drugs in the six classes of drugs that are critical to treating HIV/AIDS, mental illnesses, cancer, epilepsy, autoimmune diseases such as Crohn's, and transplant patients. As you may know, coverage of nearly all of the drugs in these categories is standard practice among state Medicaid programs and private insurers because it is more cost effective and better for people with these conditions when clinicians have the flexibility to prescribe the drug or drugs most appropriate to manage the condition according to factors unique to them.

Passage of this bill is important because the current protections for these drug classes offered in Centers for Medicare and Medicaid (CMS) guidance are not guaranteed beyond this year and are being ignored by drug plans with no risk of sanctions. Surveys of HIV and mental health medical providers indicate that Medicare beneficiaries with these conditions have been hospitalized or experienced dangerous treatment interruptions due to challenges with Medicare Part D coverage, including burdensome prior authorization processes. Many of the beneficiaries reporting problems are very low-income and live on Supplemental Security Income (SSI) checks or modest disability payments. Paying out of pocket for drugs denied by Medicare Part D drug plans is not an option for most.

On behalf of Medicare beneficiaries with these life-threatening illnesses, thank you for your leadership in working to ensure access to critical medications through Medicare Part D by requiring drug plans to cover ''all or substantially all'' of the drugs available to treat these serious, but treatable conditions.

AMERICAN PSYCHIATRIC ASSOCIATION,
Arlington, VA, July 24, 2007.

Hon. GORDON SMITH,
U.S. Senate, 404 Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: I am writing on behalf of the American Psychiatric Association (AP A), the medical specialty representing more than 38,000 psychiatric physicians nationwide, to express our strong support for your Medicare Access to Critical Medications Act of 2007.

This bill will provide crucial protections in the Medicare Part D program for six classes of life-saving medications. Part D drug plans will be required to place substantially all anticancer, HIV/AIDS, and immunosuppressant medications on their formularies, as well as drugs that are important to people with severe mental illnesses—antipsychotics, antidepressants, and anticonvulsants. In addition, when a drug plan and a patient's physician disagree about whether a critical medication is needed, your legislation will require that the medication be covered until the appeals process can be completed.

Unfortunately, data from the first year of the Part D program point to the need for additional protections for patients with serious diseases. In 2006, an American Psychiatric Institute for Research and Education (APIRE) study tracked 1,193 dually-eligible Medicare/Medicaid psychiatric patients and found that 53.4 percent experienced at least one problem with medication access or continuity. Among these patients, 19.8 percent had a subsequent emergency room visit reported, and 11 percent had a hospitalization.

Furthermore, the study found that the most common medication classes with coverage problems included atypical antipsychotics, antidepressants, and anticonvulsants (West, Wilk, Muszynski et al, American Journal of Psychiatry, 164:5 May 2007).

Clearly, Part D patients will receive better care, and the Medicare program as a whole will save money, if access to important medications can be improved. Your legislation will create new statutory protections that will address a number of the most serious barriers.

We greatly appreciate your leadership—and the hard work of your staff Matthew Canedy and Catherine Finley—in addressing this serious problem.

Sincerely,

CAROLYN B. ROBINOWITZ, M.D.,
President.

By Ms. CANTWELL (for herself, Ms. SNOWE, Mr. INOUYE, Mr. STEVENS, Mr. LAUTENBERG, and Mr. LOTT):

S. 1892. A bill to reauthorize the Coast Guard for fiscal year 2008, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Ms. CANTWELL. Mr. President, I rise today to introduce the Coast Guard Authorization Act for the fiscal year 2008 along with Senators SNOWE, INOUYE, STEVENS, LAUTENBERG, and LOTT. This comprehensive legislation will provide the Coast Guard with needed resources to carry out missions critical to our Nation's security, environmental protection, and fisheries enforcement.

The U.S. Coast Guard plays a critical role in keeping our oceans, coasts, and waterways safe, secure, and free from environmental harm. After September 11 and Hurricane Katrina, the Coast Guard has been a source of strength. As marine traffic grows, the number of security threats in our ports increases. Climate change is raising the stakes of another Katrina happening.

The Coast Guard faces many challenges, and those serving in the Coast Guard routinely serve with discipline and courage. From saving lives during natural disasters like Hurricanes Katrina and Rita, to protecting our shores in a post-9/11 world, the Coast Guard has served America well, and continues to serve us every day.

Each year, maritime smugglers transport thousands of aliens to the U.S. with virtual impunity because the existing law does not sufficiently punish or deter such conduct. During fiscal years 2004 and 2005, over 840 mariners made $13.9 million smuggling people into the U.S. illegally. Less than 3 percent of those who were interdicted were referred for prosecution.

This bill gives the Coast Guard the authority it needs to prosecute mariners who intentionally smuggle aliens on board their vessels with a reckless disregard of our laws. It also provides protection for legitimate mariners who encounter stowaways or those who may need medical attention.

Our Nation relies heavily on polar icebreakers to conduct missions in the Arctic and Antarctic. They conduct vital research on the oceans and climate, resupply U.S. outposts in Antarctica, and provide one of our Nation's only platforms for carrying out security and rescue missions in some of the world's most rapidly changing environments.

Currently, the United States' icebreaking capabilities lie with the Coast Guard's three vessels: the *HEALY*; the *Polar Sea*; and the *Polar Star*. But the fleet is aging rapidly and requires extensive maintenance. In fact, the *Polar Star* is currently not even operational because the Coast Guard lacks the resources required to maintain this vessel.

With increased climate change, the role of icebreakers is changing. With an ice-free Arctic summer expected by 2050, more and more international expeditions will be headed to the region to examine newly revealed oil and gas reserves and other natural resources.

Canada, Russia and other countries will begin to compete with America over jurisdiction and, without a strong polar icebreaker fleet, our Nation will suffer a severe disadvantage.

A recent 2007 report by the National Academy of Sciences found that the U.S. needs to maintain polar icebreaking capacity and construct at least two new polar icebreakers. This bill follows those recommendations.

This bill includes many provisions of the Oil Pollution Prevention and Response Act of 2007, which I introduced on June 14, 2007. These provisions are vital for the environmental protection of our Nation's oceans and coasts. For example, this bill would require improved coordination with federally-recognized tribes on oil spill prevention, preparedness, and response. It would also address oil spills resulting from the transfer of oil to or from vessels, spills resulting from human error, and small oil spills that are an all-too-common occurrence in many of our waterways.

For my home State of Washington, it provides a mechanism for year-round funding of the Neah Bay response tug, a key element of the oil spill prevention safety net for Washington State's Olympic Coast. It would also increase oil spill preparedness in the Strait of Juan de Fuca by changing the definition of ''High Volume Port Line'' so as to deliver better incident response throughout Puget Sound.

The Coast Guard is responsible for ensuring our country's security, marine safety and protecting our environment and fisheries. Every day the Coast Guard carries out these missions and does so with limited resources. It is our job to ensure the Coast Guard has the tools it requires to continue getting the job done. This bill will go a long way towards that goal. I urge my colleagues to consider this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1892

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Coast Guard Authorization Act for Fiscal Year 2008''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—AUTHORIZATIONS

SEC. 101. AUTHORIZATION OF APPROPRIATIONS.

Funds are authorized to be appropriated for necessary expenses of the Coast Guard for fiscal year 2008 as follows:

(1) For the operation and maintenance of the Coast Guard, $5,894,295,000, of which $24,500,000 is authorized to be derived from the Oil Spill Liability Trust Fund to carry out the purposes of section 1012(a)(5) of the Oil Pollution Act of 1990.

(2) For the acquisition, construction, renovation, and improvement of aids to navigation, shore and offshore facilities, vessels, and aircraft, including equipment related thereto, $998,068,000, of which $20,000,000 shall be derived from the Oil Spill Liability Trust Fund to carry out the purposes of section 1012(a)(5) of the Oil Pollution Act of 1990, to remain available until expended; such funds appropriated for personnel compensation and benefits and related costs of acquisition, construction, and improvements shall be available for procurement of services necessary to carry out the Integrated Deepwater Systems program.

(3) For retired pay (including the payment of obligations otherwise chargeable to lapsed appropriations for this purpose), payments under the Retired Serviceman's Family Protection and Survivor Benefit Plans, and payments for medical care of retired personnel and their dependents under chapter 55 of title 10, United States Code, $1,184,720,000.

(4) For environmental compliance and restoration functions under chapter 19 of title 14, United States Code, $12,079,000.

(5) For research, development, test, and evaluation programs related to maritime technology, $17,583,000.

(6) For operation and maintenance of the Coast Guard reserve program, $126,883,000.

(7) For the construction of a new Chelsea Street Bridge in Chelsea, Massachusetts, $3,000,000.

SEC. 102. AUTHORIZED LEVELS OF MILITARY STRENGTH AND TRAINING.

(a) ACTIVE DUTY STRENGTH.—The Coast Guard is authorized an end-of-year strength of active duty personnel of 45,500 as of September 30, 2008.

(b) MILITARY TRAINING STUDENT LOADS.—For fiscal year 2008, the Coast Guard is authorized average military training student loads as follows:

(1) For recruit and special training, 2,500 student years.

(2) For flight training, 165 student years.

(3) For professional training in military and civilian institutions, 350 student years.

(4) For officer acquisition, 1,200 student years.

SEC. 103. WEB-BASED RISK MANAGEMENT DATA SYSTEM.

(a) IN GENERAL.—There are authorized to be appropriated $1,000,000 for each of fiscal years 2008 and 2009 to the Secretary of the department in which the Coast Guard is operating to continue deployment of a World Wide Web-based risk management system to help reduce accidents and fatalities.

(b) IMPLEMENTATION STATUS REPORT.—Within 90 days after the date of enactment of this Act, the Commandant of the Coast Guard shall submit a report to the Senate Committee on Commerce, Science, and Transportation on the status of implementation of the system.

TITLE II—ORGANIZATION

SEC. 201. VICE COMMANDANT; VICE ADMIRALS.

(a) VICE COMMANDANT.—The fourth sentence of section 47 of title 14, United States Code, is amended by striking ''vice admiral'' and inserting ''admiral''.

(b) VICE ADMIRALS.—Section 50 of such title is amended to read as follows:

''§ 50. Vice admirals

''(a)(1) The President may designate no more than 4 positions of importance and responsibility that shall be held by officers who—

''(A) while so serving, shall have the grade of vice admiral, with the pay and allowances of that grade; and

''(B) shall perform such duties as the Commandant may prescribe.

''(2) The President may appoint, by and with the advice and consent of the Senate, and reappoint, by and with the advice and consent of the Senate, to any such position an officer of the Coast Guard who is serving on active duty above the grade of captain. The Commandant shall make recommendations for such appointments.

''(b)(1) The appointment and the grade of vice admiral shall be effective on the date the officer assumes that duty and, except as provided in paragraph (2) of this subsection or in section 51(d) of this title, shall terminate on the date the officer is detached from that duty.

''(2) An officer who is appointed to a position designated under subsection (a) shall continue to hold the grade of vice admiral—

''(A) while under orders transferring the officer to another position designated under subsection (a), beginning on the date the officer is detached from that duty and terminating on the date before the day the officer assumes the subsequent duty, but not for more than 60 days;

''(B) while hospitalized, beginning on the day of the hospitalization and ending on the day the officer is discharged from the hospital, but not for more than 180 days; and

''(C) while awaiting retirement, beginning on the date the officer is detached from duty and ending on the day before the officer's retirement, but not for more than 60 days.

''(c)(1) An appointment of an officer under subsection (a) does not vacate the permanent grade held by the officer.

''(2) An officer serving in a grade above rear admiral who holds the permanent grade of rear admiral (lower half) shall be considered for promotion to the permanent grade of rear admiral as if the officer was serving in the officer's permanent grade.

''(d) Whenever a vacancy occurs in a position designated under subsection (a), the Commandant shall inform the President of the qualifications needed by an officer serving in that position or office to carry out effectively the duties and responsibilities of that position or office.''.

(c) REPEAL.—Section 50a of such title is repealed.

(d) CONFORMING AMENDMENTS.—Section 51 of such title is amended—

(1) by striking subsections (a), (b), and (c) and inserting the following:

''(a) An officer, other than the Commandant, who, while serving in the grade of admiral or vice admiral, is retired for physical disability shall be placed on the retired list with the highest grade in which that officer served.

''(b) An officer, other than the Commandant, who is retired while serving in the grade of admiral or vice admiral, or who, after serving at least 2½ years in the grade of admiral or vice admiral, is retired while serving in a lower grade, may in the discretion of the President, be retired with the highest grade in which that officer served.

''(c) An officer, other than the Commandant, who, after serving less than 2½ years in the grade of admiral or vice admiral, is retired while serving in a lower grade, shall be retired in his permanent grade.''; and

(2) by striking ''Area Commander, or Chief of Staff'' in subsection (d)(2) and inserting ''or Vice Admiral''.

(e) CLERICAL AMENDMENTS.—

(1) The section caption for section 47 of such title is amended to read as follows:

''§ 47. Vice commandant; appointment''.

(2) The chapter analysis for chapter 3 of such title is amended—

(A) by striking the item relating to section 47 and inserting the following:

''47. Vice Commandant; appointment'';

(B) by striking the item relating to section 50a; and

(C) by striking the item relating to section 50 and inserting the following:

''50. Vice admirals''.

(f) TECHNICAL CORRECTION.—Section 47 of such title is further amended by striking ''subsection'' in the fifth sentence and inserting ''section''.

SEC. 202. MERCHANT MARINER MEDICAL ADVISORY COMMITTEE.

(a) IN GENERAL.—Chapter 3 of title 14, United States Code, is amended by adding at the end the following new section:

''§ 55. Merchant Mariner Medical Advisory Committee

''(a) ESTABLISHMENT; MEMBERSHIP; STATUS.—

''(1) There is established a Merchant Mariner Medical Advisory Committee.

''(2) The Committee shall consist of 12 members, none of whom shall be a Federal employee—

''(A) 10 of whom shall be health-care professionals with particular expertise, knowledge, or experience regarding the medical examinations of merchant mariners or occupational medicine; and

''(B) 2 of whom shall be professional mariners with knowledge and experience in mariner occupational requirements.

''(3) Members of the Committee shall not be considered Federal employees or otherwise in the service or the employment of the Federal Government, except that members shall be considered special Government employees, as defined in section 202(a) of title 18 and any administrative standards of conduct applicable to the employees of the department in which the Coast Guard is operating.

''(b) APPOINTMENTS; TERMS; VACANCIES; ORGANIZATION.—

''(1) The Secretary shall appoint the members of the Committee, and each member shall serve at the pleasure of the Secretary.

''(2) The members shall be appointed for a term of 3 years, except that, of the members first appointed, 3 members shall be appointed for a term of 2 years and 3 members shall be appointed for a term of 1 year.

''(3) Any member appointed to fill the vacancy prior to the expiration of the term for which such member's predecessor was appointed shall be appointed for the remainder of such term.

''(4) The Secretary shall designate 1 member as the Chairman and 1 member as the Vice Chairman. The Vice Chairman shall act as Chairman in the absence or incapacity of, or in the event of a vacancy in the office of, the Chairman.

''(5) No later than 6 months after the date of enactment of the Coast Guard Authorization Act for Fiscal Year 2008, the Committee shall hold its first meeting.

''(c) FUNCTION.—The Committee shall advise the Secretary on matters relating to—

''(1) medical certification determinations for issuance of merchant mariner credentials;

''(2) medical standards and guidelines for the physical qualifications of operators of commercial vessels;

''(3) medical examiner education; and

''(4) medical research.

''(d) COMPENSATION; REIMBURSEMENT.—Members of the Committee shall serve without compensation, except that, while engaged in the performance of duties away from their homes or regular places of business of the member, the member of the Committee may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5.

''(e) STAFF; SERVICES.—The Secretary shall furnish to the Committee such personnel and services as are considered necessary for the conduct of its business.''.

(b) CLERICAL AMENDMENT.—The analysis for chapter 3 of such title is amended by adding at the end the following:

''55. Merchant Mariner Medical Advisory Committee.''.

SEC. 203. AUTHORITY TO DISTRIBUTE FUNDS THROUGH GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS TO MARITIME AUTHORITIES AND ORGANIZATIONS.

Section 149 of title 14, United States Code, is amended by adding at the end the following:

''(c) GRANTS TO INTERNATIONAL MARITIME ORGANIZATIONS.—The Commandant may, after consultation with the Secretary of State, make grants to, or enter into cooperative agreements, contracts, or other agreements with, international maritime organizations for the purpose of acquiring information or data about merchant vessel inspections, security, safety and environmental requirements, classification, and port state or flag state law enforcement or oversight.''.

SEC. 204. ASSISTANCE TO FOREIGN GOVERNMENTS AND MARITIME AUTHORITIES.

Section 149 of title 14, United States Code, is amended by adding at the end the following:

''(d) AUTHORIZED ACTIVITIES.—

''(1) The Commandant may transfer or expend funds from any appropriation available to the Coast Guard for—

''(A) the activities of traveling contact teams, including any transportation expense, translation services expense, or administrative expense that is related to such activities;

''(B) the activities of maritime authority liaison teams of foreign governments making reciprocal visits to Coast Guard units, including any transportation expense, translation services expense, or administrative expense that is related to such activities;

''(C) seminars and conferences involving members of maritime authorities of foreign governments;

''(D) distribution of publications pertinent to engagement with maritime authorities of foreign governments; and

''(E) personnel expenses for Coast Guard civilian and military personnel to the extent that those expenses relate to participation in an activity described in subparagraph (C) or (D).

''(2) An activity may not be conducted under this subsection with a foreign country unless the Secretary of State approves the conduct of such activity in that foreign country.''.

TITLE III—PERSONNEL

SEC. 301. EMERGENCY LEAVE RETENTION AUTHORITY.

Section 701(f)(2) of title 10, United States Code, is amended by inserting ''or a declaration of a major disaster or emergency by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, 42 U.S.C. 5121 et seq.)'' after ''operation''.

SEC. 302. LEGAL ASSISTANCE FOR COAST GUARD RESERVISTS.

Section 1044(a)(4) of title 10, United States Code, is amended—

(1) by striking ''(as determined by the Secretary of Defense),'' and inserting ''(as determined by the Secretary of Defense and the Secretary of the department in which the Coast Guard is operating, with respect to the Coast Guard when it is not operating as a service of the Navy),''; and

(2) by striking ''prescribed by the Secretary of Defense,'' and inserting ''prescribed by Secretary of Defense and the Secretary of the department in which the Coast Guard is operating, with respect to the Coast Guard when it is not operating as a service of the Navy,''.

SEC. 303. REIMBURSEMENT FOR CERTAIN MEDICAL-RELATED TRAVEL EXPENSES.

Section 1074i(a) of title 10, United States Code, is amended—

(1) by striking ''IN GENERAL.—In'' and inserting ''IN GENERAL.—(1) In''; and

(2) by adding at the end the following:

''(2) In any case in which a covered beneficiary resides on an INCONUS island that lacks public access roads to the mainland and is referred by a primary care physician to a specialty care provider on the mainland who provides services less than 100 miles from the location in which the beneficiary resides, the Secretary shall reimburse the reasonable travel expenses of the covered beneficiary, and, when accompaniment by an adult is necessary, for a parent or guardian of the covered beneficiary or another member of the covered beneficiary's family who is at least 21 years of age.''.

SEC. 304. NUMBER AND DISTRIBUTION OF COMMISSIONED OFFICERS ON THE ACTIVE DUTY PROMOTION LIST.

(a) IN GENERAL.—Section 42 of title 14, United States Code, is amended—

(1) by striking subsections (a), (b), and (c) and inserting the following:

''(a) The total number of Coast Guard commissioned officers on the active duty promotion list, excluding warrant officers, shall not exceed 6,700. This total number may be temporarily increased up to 2 percent for no more than the 60 days that follow the commissioning of a Coast Guard Academy class.

''(b) The total number of commissioned officers authorized by this section shall be distributed in grade not to exceed the following percentages:

''(1) 0.375 percent for rear admiral.

''(2) 0.375 percent for rear admiral (lower half).

''(3) 6.0 percent for captain.

''(4) 15.0 percent for commander.

''(5) 22.0 percent for lieutenant commander.

The Secretary shall prescribe the percentages applicable to the grades of lieutenant, lieutenant (junior grade), and ensign. The Secretary may, as the needs of the Coast Guard require, reduce any of the percentages set forth in paragraphs (1) through (5) and apply that total percentage reduction to any other lower grade or combination of lower grades.

''(c) The Secretary shall, at least once a year, compute the total number of commissioned officers authorized to serve in each grade by applying the grade distribution percentages of this section to the total number of commissioned officers listed on the current active duty promotion list. In making such calculations, any fraction shall be rounded to the nearest whole number. The number of commissioned officers on the active duty promotion list serving with other departments or agencies on a reimbursable basis or excluded under the provisions of section 324(d) of title 49, shall not be counted against the total number of commissioned officers authorized to serve in each grade.'';

(2) by striking subsection (e) and inserting the following:

''(e) The number of officers authorized to be serving on active duty in each grade of the permanent commissioned teaching staff of the Coast Guard Academy and of the Reserve serving in connection with organizing, administering, recruiting, instructing, or training the reserve components shall be prescribed by the Secretary.''; and

(3) by striking the caption of such section and inserting the following:

''§ 42. Number and distribution of commissioned officers on the active duty promotion list''.

(b) CLERICAL AMENDMENT.—The chapter analysis for chapter 3 of such title is amended by striking the item relating to section 42 and inserting the following:

''42. Number and distribution of commissioned officers on the active duty promotion list''.

SEC. 305. RESERVE COMMISSIONED WARRANT OFFICER TO LIEUTENANT PROGRAM.

Section 214(a) of title 14, United States Code, is amended to read as follows:

''(a) The President may appoint temporary commissioned officers—

''(1) in the Regular Coast Guard in a grade, not above lieutenant, appropriate to their qualifications, experience, and length of service, as the needs of the Coast Guard may require, from among the commissioned warrant officers, warrant officers, and enlisted members of the Coast Guard, and from licensed officers of the United States merchant marine; and

''(2) in the Coast Guard Reserve in a grade, not above lieutenant, appropriate to their qualifications, experience, and length of service, as the needs of the Coast Guard may require, from among the commissioned warrant officers of the Coast Guard Reserve.''.

SEC. 306. ENHANCED STATUS QUO OFFICER PROMOTION SYSTEM.

(a) Section 253(a) of title 14, United States Code, is amended—

(1) by inserting ''and'' after ''considered,''; and

(2) by striking ''consideration, and the number of officers the board may recommend for promotion'' and inserting ''consideration''.

(b) Section 258 of such title is amended—

(1) by inserting ''(a)'' before ''The Secretary''; and

(2) by adding at the end the following:

''(b) In addition to the information provided pursuant to subsection (a), the Secretary may furnish the selection board—

''(1) specific direction relating to the needs of the service for officers having particular skills, including direction relating to the need for a minimum number of officers with particular skills within a specialty; and

''(2) such other guidance that the Secretary believes may be necessary to enable the board to properly perform its functions. Selections made based on the direction and guidance provided under this subsection shall not exceed the maximum percentage of officers who may be selected from below the announced promotion zone at any given selection board convened under section 251 of this title.''.

(c) Section 259(a) of such title is amended by striking ''board'' the second place it appears and inserting ''board, giving due consideration to the needs of the service for officers with particular skills so noted in the specific direction furnished pursuant to section 258 of this title,''.

(d) Section 260(b) of such title is amended by inserting ''to meet the needs of the service (as noted in the specific direction furnished the board under section 258 of this title)'' after ''qualified for promotion''.

SEC. 307. APPOINTMENT OF CIVILIAN COAST GUARD JUDGES.

Section 875 of the Homeland Security Act of 2002 (6 U.S.C. 455) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

''(c) APPOINTMENT OF JUDGES.—The Secretary may appoint civilian employees of the Department of Homeland Security as appellate military judges, available for assignment to the Coast Guard Court of Criminal Appeals as provided for in section 866(a) of title 10, United States Code.''.

SEC. 308. COAST GUARD PARTICIPATION IN THE ARMED FORCES RETIREMENT HOME SYSTEM.

(a) ELIGIBILITY UNDER THE ARMED FORCES RETIREMENT HOME ACT.—Section 1502 of the Armed Forces Retirement Home Act of 1991 (24 U.S.C. 401) is amended—

(1) by striking ''does not include the Coast Guard when it is not operating as a service of the Navy.'' in paragraph (4) and inserting ''has the meaning given such term in section 101(4) of title 10.'';

(2) by striking ''and'' in paragraph (5)(C);

(3) by striking ''Affairs.'' in paragraph (5)(D) and inserting ''Affairs; and'';

(4) by adding at the end of paragraph (5) the following:

''(E) the Assistant Commandant of the Coast Guard for Human Resources.''; and

(5) by adding at the end of paragraph (6) the following:

''(E) The Master Chief Petty Officer of the Coast Guard.''.

(b) DEDUCTIONS.—

(1) Section 2772 of title 10, United States Code, is amended—

(A) by striking ''of the military department'' in subsection (a);

(B) by striking ''Armed Forces Retirement Home Board'' in subsection (b) and inserting ''Chief Operating Officer of the Armed Forces Retirement Home''; and

(C) by striking subsection (c).

(2) Section 1007(i) of title 37, United States Code, is amended—

(A) by striking ''Armed Forces Retirement Home Board'' in paragraph (3) and inserting ''Chief Operating Officer of the Armed Forces Retirement Home''; and

(B) by striking ''does not include the Coast Guard when it is not operating as a service of the Navy.'' in paragraph (4) and inserting ''has the meaning given such term in section 101(4) of title 10.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first pay period beginning on or after January 1, 2008.

TITLE IV—ADMINISTRATION

SEC. 401. COOPERATIVE AGREEMENTS FOR INDUSTRIAL ACTIVITIES.

Section 151 of title 14, United States Code, is amended—

(1) by inserting ''(a) IN GENERAL.—'' before ''All orders''; and

(2) by adding at the end the following:

''(b) ORDERS AND AGREEMENTS FOR INDUSTRIAL ACTIVITIES.—Under this section, the Coast Guard industrial activities may accept orders and enter into reimbursable agreements with establishments, agencies, and departments of the Department of Defense and the Department of Homeland Security.''.

SEC. 402. DEFINING COAST GUARD VESSELS AND AIRCRAFT.

(a) IN GENERAL.—Chapter 17 of title 14, United States Code, is amended by inserting after section 638 the following new section:

''§ 638a. Coast Guard vessels and aircraft defined

''For the purposes of sections 637 and 638 of this title, the term Coast Guard vessels and aircraft means—

''(1) any vessel or aircraft owned, leased, transferred to, or operated by the Coast Guard and under the command of a Coast Guard member; and

''(2) any other vessel or aircraft under the tactical control of the Coast Guard on which one or more members of the Coast Guard are assigned and conducting Coast Guard missions.''.

(b) CLERICAL AMENDMENT.—The chapter analysis for chapter 17 of such title is amended by inserting after the item relating to section 638 the following:

''638a. Coast Guard vessels and aircraft defined.''.

SEC. 403. SPECIALIZED INDUSTRIAL FACILITIES.

(a) IN GENERAL.—Section 648 of title 14, United States Code, is amended—

(1) by striking the section caption and inserting the following:

''§ 648. Specialized industrial facilities'' ;

(2) by inserting ''(a) IN GENERAL.—'' before ''The Secretary''; and

(3) by adding at the end the following:

''(b) PUBLIC-PRIVATE PARTNERSHIPS OR OTHER COOPERATIVE ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of entering into joint public-private partnerships or other cooperative arrangements for the performance of work to provide supplies or services for government use, the Coast Guard Yard, the Aviation Repair and Supply Center, or other similar Coast Guard industrial establishments may—

''(A) enter into agreements or other arrangements with public or private entities, foreign or domestic;

''(B) pursuant to contracts or other arrangements, receive and retain funds from, or pay funds to, such public or private entities; or

''(C) accept contributions of funds, materials, services, or the use of facilities from such public or private entities, subject to regulations promulgated by the Coast Guard.

''(2) ACCOUNTING FOR FUNDS RECEIVED.—Amounts received under this subsection may be credited to the Coast Guard Yard Revolving Fund or other appropriate Coast Guard account.

''(3) REIMBURSEMENT.—Any partnership, agreement, contract, or arrangement entered into under this section shall require the private entity to reimburse the Coast Guard for such entity's proportional share of the operating and capital costs of maintaining and operating such facility, as determined by the Commandant of the Coast Guard.

''(4) NONINTERFERENCE.—No partnership, agreement, contract, or arrangement entered into under this section may interfere with the performance of any operational or support function of the Coast Guard industrial establishment.''.

(b) CLERICAL AMENDMENT.—The chapter analysis for chapter 17 of such title is amended by striking item relating to section 648 and inserting the following:

''648. Specialized industrial facilities''.

SEC. 404. AUTHORITY TO CONSTRUCT COAST GUARD RECREATIONAL FACILITIES.

(a) GENERAL AUTHORITY.—Section 681 of title 14, United States Code, is amended—

(1) in subsection (a)—

(A) by striking ''housing or military unaccompanied housing'' and inserting ''housing, military unaccompanied housing, or Coast Guard recreational facilities''; and

(B) by adding at the end the following:

''(3) Coast Guard recreational facilities.''; and

(2) by striking ''housing or military unaccompanied housing'' in subsection (b) and inserting ''housing, military unaccompanied housing, or Coast Guard recreational facilities''.

(b) DIRECT LOANS.—Section 682 of such title is amended—

(1) by inserting after ''military unaccompanied housing'' in subsection (a)(1) the following: ''or facilities that the Secretary determines are suitable for use as Coast Guard recreational facilities''; and

(2) by inserting after ''military unaccompanied housing'' in subsection (b)(1) the following: ''or facilities that the Secretary determines are suitable for use as Coast Guard recreational facilities''.

(c) LEASING OF HOUSING TO BE CONSTRUCTED.—Section 683(a) of such title is amended by striking ''or military unaccompanied housing units'' and inserting ''units, military unaccompanied housing units, or Coast Guard recreational facilities''.

(d) LIMITED PARTNERSHIPS WITH ELIGIBLE ENTITIES.—Section 684 of such title is amended—

(1) by inserting after ''military unaccompanied housing'' in subsection (a) the following: ''or facilities that the Secretary determines are suitable for use as Coast Guard recreational facilities'';

(2) by striking ''construction of housing, means the total amount of the costs included in the basis of the housing'' in subsection (b)(3) and inserting ''construction of housing or facilities, means the total amount of the costs included in the basis of the housing or facilities''; and

(3) by inserting ''or facilities'' in subsection (c) after ''housing units''.

(e) DEPOSIT OF CERTAIN AMOUNTS IN COAST GUARD HOUSING FUND.—Section 687 of such title is amended—

(1) in subsection (b)—

(A) in paragraph (2), by striking ''or unaccompanied housing'' and inserting '', military unaccompanied housing, or Coast Guard recreational facilities''; and

(B) in paragraph (3), by striking ''and military unaccompanied housing'' and inserting '', military unaccompanied housing, and Coast Guard recreational facilities''; and

(2) by striking ''and military unaccompanied housing units'' in subsection (c)(1) and inserting '', military unaccompanied housing units, and Coast Guard recreational facilities''.

(f) REPORTS.—Section 688 of such title is amended—

(1) by inserting after ''housing units'' in paragraph (1) the following: ''or Coast Guard recreational facilities''; and

(2) by striking ''and military unaccompanied housing'' in paragraph (4) and inserting '', military unaccompanied housing, and Coast Guard recreational facilities''.

(g) DEFINITIONS.—Section 680 of such title is amended—

(1) by redesignating paragraphs (1) through (5) as paragraphs (2) through (6), respectively;

(2) by inserting before paragraph (2), as redesignated by paragraph (1) of this subsection, the following:

''(1) The term 'Coast Guard recreational facilities' means recreation lodging buildings, recreation housing units, and ancillary supporting facilities constructed, maintained, and used by the Coast Guard to provide rest and recreation amenities for military personnel.''; and

(3) by striking ''housing units and ancillary supporting facilities or the improvement or rehabilitation of existing units'' in paragraph (2), as redesignated by paragraph (1) of this subsection, and inserting ''housing units or Coast Guard recreational facilities and ancillary supporting facilities or the improvement or rehabilitation of existing units or facilities''.

TITLE V—SHIPPING AND NAVIGATION

SEC. 501. TECHNICAL AMENDMENTS TO CHAPTER 313 OF TITLE 46, UNITED STATES CODE.

(a) IN GENERAL.—Chapter 313 of title 46, United States Code, is amended—

(1) by striking ''of Transportation'' in sections 31302, 31306, 31321, 31330, and 31343 each place it appears;

(2) by striking ''and'' after the semicolon in section 31301(5)(F);

(3) by striking ''office.'' in section 31301(6) and inserting ''office; and''; and

(4) by adding at the end of section 31301 the following:

''(7) 'Secretary' means the Secretary of the Department of Homeland Security, unless otherwise noted.''.

(b) SECRETARY AS MORTGAGEE.—Section 31308 of such title is amended by striking ''When the Secretary of Commerce or Transportation is a mortgagee under this chapter, the Secretary'' and inserting ''The Secretary of Commerce or Transportation, as a mortgagee under this chapter,''.

(c) SECRETARY OF TRANSPORTATION.—Section 31329(d) of such title is amended by inserting ''of Transportation'' after ''Secretary''.

(d) MORTGAGEE.—

(1) Section 31330(a)(1) of such title is amended—

(A) by inserting ''or'' after the semicolon in subparagraph (B);

(B) by striking ''Transportation; or'' in subparagraph (C) and inserting ''Transportation.''; and

(C) by striking subparagraph (D).

(2) Section 31330(a)(2) is amended—

(A) by inserting ''or'' after the semicolon in subparagraph (B);

(B) by striking ''faith; or'' in subparagraph (C) and inserting ''faith.''; and

(C) by striking subparagraph (D).

SEC. 502. CLARIFICATION OF RULEMAKING AUTHORITY.

(a) IN GENERAL.—Chapter 701 of title 46, United States Code, is amended by adding at the end the following:

''§ 70122. Regulations

''Unless otherwise provided, the Secretary may issue regulations necessary to implement this chapter.''.

(b) CLERICAL AMENDMENT.—The chapter analysis for chapter 701 of such title is amended by adding at the end the following new item:

''70122. Regulations''.

SEC. 503. COAST GUARD TO MAINTAIN LORAN-C NAVIGATION SYSTEM.

(a) IN GENERAL.—The Secretary of Transportation shall maintain the LORAN-C navigation system until such time as the Secretary is authorized by statute, explicitly referencing this section, to cease operating the system.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Transportation, in addition to funds authorized under section 101 of this Act for the Coast Guard for operation of the LORAN-C system, for capital expenses related to the LORAN-C infrastructure, $25,000,000 for each of fiscal years 2008 and 2009. The Secretary of Transportation may transfer from the Federal Aviation Administration and other agencies of the Department of Transportation such funds as may be necessary to reimburse the Coast Guard for related expenses.

SEC. 504. NANTUCKET SOUND SHIP CHANNEL WEATHER BUOY.

Within 180 days after the date of enactment of this Act, the National Weather Service shall deploy a weather buoy adjacent to the main ship channel of Nantucket Sound.

SEC. 505. LIMITATION ON MARITIME LIENS ON FISHING PERMITS.

(a) IN GENERAL.—Subchapter I of chapter 313 of title 46, United States Code, is amended by adding at the end the following:

''§ 31310. Limitation on maritime liens on fishing permits

''(a) IN GENERAL.—A maritime lien shall not attach to a permit that—

''(1) authorizes use of a vessel to engage in fishing; and

''(2) is issued under State or Federal law.

''(b) LIMITATION ON ENFORCEMENT.—No civil action may be brought to enforce a maritime lien on a permit described in subsection (a).

''(c) LIMITATION ON STATUTORY CONSTRUCTION.—Nothing in subsections (a) and (b) shall be construed as imposing any limitation upon the authority of the Secretary of Commerce to modify, suspend, revoke, or sanction any Federal fishery permit issued by the Secretary of Commerce or to bring a civil action to enforce such modification, suspension, revocation, or sanction.''.

(b) CLERICAL AMENDMENT.—The analysis for such chapter is amended by inserting after the item relating to section 31309 the following:

''31310. Limitation on maritime liens on fishing permits.''.

SEC. 506. VESSEL REBUILD DETERMINATIONS.

(a) IN GENERAL.—The Secretary of the department in which the Coast Guard is operating shall provide a report on Coast Guard rebuild determinations under section 67.177 of title 46, Code of Federal Regulations. Specifically, the report shall provide recommendations for—

(1) improving the application of the ''major component test'' under such section;

(2) a review of the application of the steelweight calculation thresholds under such section;

(3) recommendations for improving transparency in the Coast Guard's foreign rebuild determination process; and

(4) recommendations on whether or not there should be limits or cumulative caps on the amount of steel work that can be done to the hull and superstructure of a vessel in foreign shipyards over the life of the vessel.

(b) REPORT DEADLINE.—The Secretary shall provide this report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure within 90 days after the enactment of this Act.

TITLE VI—MARITIME LAW ENFORCEMENT

SEC. 601. MARITIME LAW ENFORCEMENT.

(a) IN GENERAL.—Subtitle VII of title 46, United States Code, is amended by adding at the end the following:

''CHAPTER 707—MARITIME LAW ENFORCEMENT

''§ 70701. Offense

''It shall be unlawful for any person on board a covered vessel to transport or facilitate the transportation, harboring, or concealment of an alien on board such vessel knowing or having reason to believe that the alien is attempting to unlawfully enter the United States.

''§ 70702. Attempt or conspiracy

''Any person on board a covered vessel who attempts or conspires to commit a violation of section 70701 shall be subject to the same penalties as those prescribed for the violation, the commission of which was the object of the attempt or conspiracy.

''§ 70703. Affirmative defenses

''It is an affirmative defense to a prosecution under this section, which the defendant must prove by a preponderance of the evidence, that—

''(1)(A) the alien was on board pursuant to a rescue at sea, or was a stowaway; or

''(B) the entry into the United States was a necessary response to an imminent threat of death or serious bodily injury to the alien;

''(2) the defendant, as soon as reasonably practicable, informed the Coast Guard of the presence of the alien on the vessel and the circumstances of the rescue; and

''(3) the defendant complied with all orders given by law enforcement officials of the United States.

''§ 70704. Penalties

''(a) IN GENERAL.—Any person who commits a violation of this chapter shall be fined or imprisoned, or both, in accordance with subsection (b) and (c) of this section. For purposes of subsection (b), each individual on board a vessel with respect to whom the violation occurs shall be treated as a separate violation.

''(b) FINES.—Any person who commits a violation of this chapter shall be fined not more than $100,000, except that—

''(1) in any case in which the violation causes serious bodily injury to any person, regardless of where the injury occurs, the person shall be fined not more than $500,000; and

''(2) in any case where the violation causes or results in the death of any person regardless of where the death occurs, the person shall be fined not more than $1,000,000, or both.

''(c) IMPRISONMENT.—Any person who commits a violation of this chapter shall be imprisoned for not less than 3 nor more than 20 years, except that—

''(1) in any case in which the violation causes serious bodily injury to any person, regardless of where the injury occurs, the person shall be imprisoned for not less than 7 nor more than 30 years; and

''(2) in any case where the violation causes or results in the death of any person regardless of where the death occurs, the person shall be imprisoned for not less than 10 years nor more than life.

''§ 70705. Criminal forfeiture

''The court, at the time of sentencing a person convicted of an offense under this chapter, shall order forfeited to the United States any vessel used in the offense in the same manner and to the same extent as if it were a vessel used in an offense under section 274 of the Immigration and Nationality Act (8 U.S.C. 1324).

''§ 70706. Civil forfeiture

''A vessel that has been used in the commission of a violation of this chapter shall be seized and subject to forfeiture in the same manner and to the same extent as if it were used in the commission of a violation of section 274(a) of the Immigration and Nationality Act (8 U.S.C. 1324(a)).

''§ 70707. Extraterritorial jurisdiction

''There is extraterritorial jurisdiction of an offense under this chapter.

''§ 70708. Claim of failure to comply with international law; jurisdiction of court

''A claim of failure to comply with international law in the enforcement of this chapter may be invoked as a basis for a defense solely by a foreign nation. A failure to comply with international law shall not divest a court of jurisdiction or otherwise constitute a defense to any proceeding under this chapter.

''§ 70709. Federal activities

''Nothing in this chapter applies to otherwise lawful activities carried out by or at the direction of the United States Government.

''§ 70710. Definitions

''In this chapter:

''(1) ALIEN.—The term 'alien' has the meaning given that term in section 70105(f).

''(2) COVERED VESSEL.—The term 'covered vessel' means a vessel of the United States, or a vessel subject to the jurisdiction of the United States, that is less than 300 gross tons (or an alternate tonnage prescribed by the Secretary under section 14104 of this title) as measured under section 14502 of this title.

''(3) SERIOUS BODILY INJURY.—The term 'serious bodily injury' has the meaning given that term in section 1365 of title 18, United States Code.

''(4) UNITED STATES.—The term 'United States' has the meaning given that term in section 2101.

''(5) VESSEL OF THE UNITED STATES.—The term 'vessel of the United States' has the meaning given that term in section 70502.

''(6) VESSEL SUBJECT TO THE JURISDICTION OF THE UNITED STATES.—The term 'vessel subject to the jurisdiction of the United States' has the meaning given that term in section 70502.''.

(b) CLERICAL AMENDMENT.—The analysis for such subtitle is amended by inserting after the item relating to chapter 705 the following:

''707. Maritime Law Enforcement .....70701.''.

TITLE VII—OIL POLLUTION PREVENTION

SEC. 701. RULEMAKINGS.

(a) STATUS REPORT.—

(1) IN GENERAL.—Within 90 days after the date of enactment of this Act, the Secretary shall provide a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure on the status of all Coast Guard rulemakings required (but for which no final rule has been issued as of the date of enactment of this Act)—

(A) under the Oil Pollution Act of 1990 (33 U.S.C. 2701 et seq.); and

(B) for—

(i) automatic identification systems required under section 70114 of title 46, United States Code; and

(ii) inspection requirements for towing vessels required under section 3306(j) of that title.

(2) INFORMATION REQUIRED.—The Secretary shall include in the report required by paragraph (1)—

(A) a detailed explanation with respect to each such rulemaking as to—

(i) what steps have been completed;

(ii) what areas remain to be addressed; and

(iii) the cause of any delays; and

(B) the date by which a final rule may reasonably be expected to be issued.

(b) FINAL RULES.—The Secretary shall issue a final rule in each pending rulemaking under the Oil Pollution Act of 1990 (33 U.S.C. 2701 et seq.) as soon as practicable, but in no event later than 18 months after the date of enactment of this Act.

SEC. 702. OIL SPILL RESPONSE CAPABILITY.

(a) SAFETY STANDARDS FOR TOWING VESSELS.—In promulgating regulations for towing vessels under chapter 33 of title 46, United States Code, the Secretary of the department in which the Coast Guard is operating shall—

(1) give priority to completing such regulations for towing operations involving tank vessels; and

(2) consider the possible application of standards that, as of the date of enactment of this Act, apply to self-propelled tank vessels, and any modifications that may be necessary for application to towing vessels due to ship design, safety, and other relevant factors.

(b) REDUCTION OF OIL SPILL RISK IN BUZZARDS BAY.—No later than January 1, 2008, the Secretary of the department in which the Coast Guard is operating shall promulgate a final rule for Buzzards Bay, Massachusetts, pursuant to the notice of proposed rulemaking published on March 29, 2006, (71 Fed. Reg. 15649), after taking into consideration public comments submitted pursuant to that notice, to adopt measures to reduce the risk of oil spills in Buzzards Bay, Massachusetts.

(c) REPORTING.—The Secretary shall transmit an annual report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Resources on the extent to which tank vessels in Buzzards Bay, Massachusetts, are using routes recommended by the Coast Guard.

SEC. 703. OIL TRANSFERS FROM VESSELS.

(a) REGULATIONS.—Within 1 year after the date of enactment of this Act, the Secretary shall promulgate regulations to reduce the risks of oil spills in operations involving the transfer of oil from or to a tank vessel. The regulations—

(1) shall focus on operations that have the highest risks of discharge, including operations at night and in inclement weather; and

(2) shall consider—

(A) requirements for use of equipment, such as putting booms in place for transfers;

(B) operational procedures such as manning standards, communications protocols, and restrictions on operations in high-risk areas; or

(C) both such requirements and operational procedures.

(b) APPLICATION WITH STATE LAWS.—The regulations promulgated under subsection (a) do not preclude the enforcement of any State law or regulation the requirements of which are at least as stringent as requirements under the regulations (as determined by the Secretary) that—

(1) applies in State waters;

(2) does not conflict with, or interfere with the enforcement of, requirements and operational procedures under the regulations; and

(3) has been enacted or promulgated before the date of enactment of this Act.

SEC. 704. IMPROVEMENTS TO REDUCE HUMAN ERROR AND NEAR-MISS INCIDENTS.

(a) REPORT.—Within 1 year after the date of enactment of this Act, the Secretary shall transmit a report to the Senate Committee on Commerce, Science, and Transportation, the Senate Committee on Environment and Public Works, and the House of Representatives Committee on Transportation and Infrastructure that, using available data—

(1) identifies the types of human errors that, combined, account for over 50 percent of all oil spills involving vessels that have been caused by human error in the past 10 years;

(2) identifies the most frequent types of near-miss oil spill incidents involving vessels such as collisions, groundings, and loss of propulsion in the past 10 years;

(3) describes the extent to which there are gaps in the data with respect to the information required under paragraphs (1) and (2) and explains the reason for those gaps; and

(4) includes recommendations by the Secretary to address the identified types of errors and incidents and to address any such gaps in the data.

(b) MEASURES.—Based on the findings contained in the report required by subsection (a), the Secretary shall take appropriate action, both domestically and at the International Maritime Organization, to reduce the risk of oil spills from human errors.

SEC. 705. OLYMPIC COAST NATIONAL MARINE SANCTUARY.

(a) OLYMPIC COAST NATIONAL MARINE SANCTUARY AREA TO BE AVOIDED.—The Secretary and the Under Secretary of Commerce for Oceans and Atmosphere shall revise the area

to be avoided off the coast of the State of Washington so that restrictions apply to all vessels required to prepare a response plan under section 311(j) of the Federal Water Pollution Control Act (33 U.S.C. 1321(j)) (other than fishing or research vessels while engaged in fishing or research within the area to be avoided).

(b) EMERGENCY OIL SPILL DRILL.—

(1) IN GENERAL.—In cooperation with the Secretary, the Under Secretary of Commerce for Oceans and Atmosphere shall conduct a Safe Seas oil spill drill in the Olympic Coast National Marine Sanctuary in fiscal year 2008. The Secretary and the Under Secretary of Commerce for Oceans and Atmosphere jointly shall coordinate with other Federal agencies, State, local, and tribal governmental entities, and other appropriate entities, in conducting this drill.

(2) OTHER REQUIRED DRILLS.—Nothing in this subsection supersedes any Coast Guard requirement for conducting emergency oil spill drills in the Olympic Coast National Marine Sanctuary. The Secretary shall consider conducting regular field exercises, such as National Preparedness for Response Exercise Program (PREP) in other national marine sanctuaries.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Under Secretary of Commerce for Oceans and Atmosphere for fiscal year 2008 $700,000 to carry out this subsection.

SEC. 706. PREVENTION OF SMALL OIL SPILLS.

(a) IN GENERAL.—The Under Secretary of Commerce for Oceans and Atmosphere, in consultation with other appropriate agencies, shall establish an oil spill prevention and education program for small vessels. The program shall provide for assessment, outreach, and training and voluntary compliance activities to prevent and improve the effective response to oil spills from vessels and facilities not required to prepare a vessel response plan under the Federal Water Pollution Control Act, including recreational vessels, commercial fishing vessels, marinas, and aquaculture facilities. The Under Secretary may provide grants to sea grant colleges and institutes designated under section 207 of the National Sea Grant College Program Act (33 U.S.C. 1126) and to State agencies, tribal governments, and other appropriate entities to carry out—

(1) regional assessments to quantify the source, incidence and volume of small oil spills, focusing initially on regions in the country where, in the past 10 years, the incidence of such spills is estimated to be the highest;

(2) voluntary, incentive-based clean marina programs that encourage marina operators, recreational boaters and small commercial vessel operators to engage in environmentally sound operating and maintenance procedures and best management practices to prevent or reduce pollution from oil spills and other sources;

(3) cooperative oil spill prevention education programs that promote public understanding of the impacts of spilled oil and provide useful information and techniques to minimize pollution including methods to remove oil and reduce oil contamination of bilge water, prevent accidental spills during maintenance and refueling and properly cleanup and dispose of oil and hazardous substances; and

(4) support for programs, including outreach and education to address derelict vessels and the threat of such vessels sinking and discharging oil and other hazardous substances, including outreach and education to involve efforts to the owners of such vessels.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Under Secretary of Commerce for Oceans and Atmosphere to carry out this section, $10,000,000 annually for each of fiscal years 2008 through 2012.

SEC. 707. IMPROVED COORDINATION WITH TRIBAL GOVERNMENTS.

(a) IN GENERAL.—Within 6 months after the date of enactment of this Act, the Secretary shall complete the development of a tribal consultation policy, which recognizes and protects to the maximum extent practicable tribal treaty rights and trust assets in order to improve the Coast Guard's consultation and coordination with the tribal governments of federally recognized Indian tribes with respect to oil spill prevention, preparedness, response and natural resource damage assessment.

(b) NATIONAL PLANNING.—The Secretary shall assist tribal governments to participate in the development and capacity to implement the National Contingency Plan and local Area Contingency Plans to the extent they affect tribal lands, cultural and natural resources. The Secretary shall ensure that in regions where oil spills are likely to have an impact on natural or cultural resources owned or utilized by a federally recognized Indian tribe, the Coast Guard will—

(1) ensure that representatives of the tribal government of the potentially affected tribes are included as part of the regional response team cochaired by the Coast Guard and the Environmental Protection Agency to establish policies for responding to oil spills; and

(2) provide training of tribal incident commanders and spill responders.

(c) INCLUSION OF TRIBAL GOVERNMENT.—The Secretary shall ensure that, as soon as practicable after identifying an oil spill that is likely to have an impact on natural or cultural resources owned or utilized by a federally recognized Indian tribe, the Coast Guard will—

(1) ensure that representatives of the tribal government of the affected tribes are included as part of the incident command system established by the Coast Guard to respond to the spill;

(2) share information about the oil spill with the tribal government of the affected tribe; and

(3) to the extent practicable, involve tribal governments in deciding how to respond to such spill.

(d) COOPERATIVE ARRANGEMENTS.—The Coast Guard may enter into memoranda of agreement and associated protocols with Indian tribal governments in order to establish cooperative arrangements for oil pollution prevention, preparedness, and response. Such memoranda may be entered into prior to the development of the tribal consultation and coordination policy to provide Indian tribes grant and contract assistance and may include training for preparedness and response and provisions on coordination in the event of a spill. As part of these memoranda of agreement, the Secretary may carry out demonstration projects to assist tribal governments in building the capacity to protect tribal treaty rights and trust assets from oil spills to the maximum extent possible.

(e) FUNDING FOR TRIBAL PARTICIPATION.—Subject to the availability of appropriations, the Commandant of the Coast Guard shall provide assistance to participating tribal governments in order to facilitate the implementation of cooperative arrangements under subsection (d) and ensure the participation of tribal governments in such arrangements. There are authorized to be appropriated to the Commandant $500,000 for each of fiscal years 2008 through 2012 to be used to carry out this section.

SEC. 708. REPORT ON THE AVAILABILITY OF TECHNOLOGY TO DETECT THE LOSS OF OIL.

Within 1 year after the date of enactment of this Act, the Secretary shall submit a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Energy and Commerce on the availability, feasibility, and potential cost of technology to detect the loss of oil carried as cargo or as fuel on tank and non-tank vessels greater than 400 gross tons.

SEC. 709. USE OF OIL SPILL LIABILITY TRUST FUND.

Section 1012(a)(5) of the Oil Pollution Act of 1990 (33 U.S.C. 2712(a)(5)) is amended—

(1) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively; and

(2) by inserting after subparagraph (A) the following:

''(B) not more than $15,000,000 in each fiscal year shall be available to the Under Secretary of Commerce for Oceans and Atmosphere for expenses incurred by, and activities related to, response and damage assessment capabilities of the National Oceanic and Atmospheric Administration;''.

SEC. 710. INTERNATIONAL EFFORTS ON ENFORCEMENT.

The Secretary, in consultation with the heads of other appropriate Federal agencies, shall ensure that the Coast Guard pursues stronger enforcement in the International Maritime Organization of agreements related to oil discharges, including joint enforcement operations, training, and stronger compliance mechanisms.

SEC. 711. GRANT PROJECT FOR DEVELOPMENT OF COST-EFFECTIVE DETECTION TECHNOLOGIES.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Commandant shall establish a grant program for the development of cost-effective technologies, such as infrared, pressure sensors, and remote sensing, for detecting discharges of oil from vessels as well as methods and technologies for improving detection and recovery of submerged and sinking oils.

(b) MATCHING REQUIREMENT.—The Federal share of any project funded under subsection (a) may not exceed 50 percent of the total cost of the project.

(c) REPORT TO CONGRESS.—Not later than 3 years after the date of enactment of this Act the Secretary shall provide a report to the Senate Committee on Commerce, Science, and Transportation, and to the House of Representatives Committee on Transportation and Infrastructure on the results of the program.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commandant to carry out this section $2,000,000 for each of fiscal years 2008, 2009, and 2010, to remain available until expended.

(e) TRANSFER PROHIBITED.—Administration of the program established under subsection (a) may not be transferred within the Department of Homeland Security or to another department or Federal agency.

SEC. 712. HIGHER VOLUME PORT AREA REGULATORY DEFINITION CHANGE.

(a) IN GENERAL.—Within 30 days after the date of enactment of this Act, notwithstanding subchapter 5 of title 5, United States Code, the Commandant shall modify the definition of the term ''higher volume port area'' in section 155.1020 of the Coast Guard regulations (33 C.F.R. 155.1020) by striking ''Port Angeles, WA'' in paragraph (13) of that section and inserting ''Cape Flattery, WA'' without initiating a rulemaking proceeding.

(b) EMERGENCY RESPONSE PLAN REVIEWS.—Within 5 years after the date of enactment of

this Act, the Coast Guard shall complete its review of any changes to emergency response plans pursuant to the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.) resulting from the modification of the higher volume port area definition required by subsection (a).

SEC. 713. RESPONSE TUGS.

(a) IN GENERAL.—Paragraph (5) of section 311(j) of the Federal Water Pollution Control Act (33 U.S.C. 1321(j)) is amended by adding at the end the following:

''(J) RESPONSE TUG.—

''(i) IN GENERAL.—The Secretary shall require the stationing of a year round response tug of a minimum of 70-tons bollard pull in the entry to the Strait of Juan de Fuca at Neah Bay capable of providing rapid assistance and towing capability to disabled vessels during severe weather conditions.

''(ii) SHARED RESOURCES.—The Secretary may authorize compliance with the response tug stationing requirement of clause (i) through joint or shared resources between or among entities to which this subsection applies.

''(iii) EXISTING STATE AUTHORITY NOT AFFECTED.—Nothing in this subparagraph supersedes or interferes with any existing authority of a State with respect to the stationing of rescue tugs in any area under State law or regulations.

''(iv) ADMINISTRATION.—In carrying out this subparagraph, the Secretary—

''(I) shall require the vessel response plan holders to negotiate and adopt a cost-sharing formula and a schedule for carrying out this subparagraph by no later than June 1, 2008;

''(II) shall establish a cost-sharing formula and a schedule for carrying out this subparagraph by no later than July 1, 2008 (without regard to the requirements of chapter 5 of title 5, United States Code) if the vessel response plan holders fail to adopt the cost-sharing formula and schedule required by subclause (I) of this clause by June 1, 2008; and

''(III) shall implement clauses (i) and (ii) of this subparagraph by June 1, 2008, without a rulemaking and without regard to the requirements of chapter 5 of title 5, United States Code.

''(v) LONG TERM TUG CAPABILITIES.—Within 6 months after implementing clauses (i) and (ii), and section 707 of the Coast Guard Authorization Act for Fiscal Year 2008, the Secretary shall execute a contract with the National Academy of Sciences to conduct a study of regional response tug and salvage needs for Washington's Olympic coast. In developing the scope of the study, the National Academy of Sciences shall consult with Federal, State, and Tribal trustees as well as relevant stakeholders. The study—

''(I) shall define the needed capabilities, equipment, and facilities for a response tug in the entry to the Strait of Juan de Fuca at Neah Bay in order to optimize oil spill protection on Washington's Olympic coast, provide rescue towing services, oil spill response, and salvage and fire-fighting capabilities;

'''(II) shall analyze the tug's multi-mission capabilities as well as its ability to utilize cached salvage, oil spill response, and oil storage equipment while responding to a spill or a vessel in distress and make recommendations as to the placement of this equipment;

''(III) shall address scenarios that consider all vessel types and weather conditions and compare current Neah Bay tug capabilities, costs, and benefits with other United States industry funded response tugs, including those currently operating in Alaska's Prince William Sound;

''(IV) shall determine whether the current level of protection afforded by the Neah Bay response tug and associated response equipment is comparable to protection in other locations where response tugs operate, including Prince William Sound, and if it is not comparable, shall make recommendations as to how capabilities, equipment, and facilities should be modified to achieve optimum protection.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary for fiscal year 2008 such sums as necessary to carry out section 311(j)(5)(J)(v) of the Federal Water Pollution Control Act (33 U.S.C. 1321(j)(5)(J)(v)).

SEC. 714. TUG ESCORTS FOR LADEN OIL TANKERS.

Within 1 year after the date of enactment of this Act, the Secretary of State, in consultation with the Commandant, shall enter into negotiations with the Government of Canada to ensure that tugboat escorts are required for all tank ships with a capacity over 40,000 deadweight tons in the Strait of Juan de Fuca, Strait of Georgia, and in Haro Strait. The Commandant shall consult with the State of Washington and affected tribal governments during negotiations with the Government of Canada.

SEC. 715. EXTENSION OF FINANCIAL RESPONSIBILITY.

Section 1016(a) of the Oil Pollution Act of 1990 (33 U.S.C. 2716(a)) is amended—

(1) by striking ''or'' after the semicolon in paragraph (1);

(2) by inserting ''or'' after the semicolon in paragraph (2); and

(3) by inserting after paragraph (2) the following:

''(3) any tank vessel over 100 gross tons (except a non-self-propelled vessel that does not carry oil as cargo) using any place subject to the jurisdiction of the United States;''.

SEC. 716. VESSEL TRAFFIC RISK ASSESSMENTS.

(a) REQUIREMENT.—The Commandant of the Coast guard, acting through the appropriate Area Committee established under section 311(j)(4) of the Federal Water Pollution Control Act, shall prepare a vessel traffic risk assessment—

(1) for Cook Inlet, Alaska, within 1 year after the date of enactment of this Act; and

(2) for the Aleutian Islands, Alaska, within 2 years after the date of enactment of this Act.

(b) CONTENTS.—Each of the assessments shall describe, for the region covered by the assessment—

(1) the amount and character of present and estimated future shipping traffic in the region; and

(2) the current and projected use and effectiveness in reducing risk, of—

(A) traffic separation schemes and routing measures;

(B) long-range vessel tracking systems developed under section 70115 of title 46, United States Code;

(C) towing, response, or escort tugs;

(D) vessel traffic services;

(E) emergency towing packages on vessels;

(F) increased spill response equipment including equipment appropriate for severe weather and sea conditions;

(G) the Automatic Identification System developed under section 70114 of title 46, United States Code;

(H) particularly sensitive sea areas, areas to be avoided, and other traffic exclusion zones;

(i) aids to navigation; and

(J) vessel response plans.

(c) RECOMMENDATIONS.—

(1) IN GENERAL.—Each of the assessments shall include any appropriate recommendations to enhance the safety and security, or lessen potential adverse environmental impacts, of marine shipping.

(2) CONSULTATION.—Before making any recommendations under paragraph (1) for a region, the Area Committee shall consult with affected local, State, and Federal government agencies, representatives of the fishing industry, Alaska Natives from the region, the conservation community, and the merchant shipping and oil transportation industries.

(d) PROVISION TO CONGRESS.—The Commandant shall provide a copy of each assessment to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commandant $1,800,000 for each of fiscal years 2008 and 2009 to conduct the assessments.

SEC. 717. OIL SPILL LIABILITY TRUST FUND INVESTMENT AMOUNT.

Within 30 days after the date of enactment of this Act, the Secretary of the Treasury shall increase the amount invested in income producing securities under section 5006(b) of the Oil Pollution Act of 1990 (33 U.S.C. 2736(b)) by $12,851,340..

SEC. 718. LIABILITY FOR USE OF UNSAFE SINGLE-HULL VESSELS.

Section 1001(32) of the Oil Pollution Act of 1990 (33 U.S.C. 2701(32)) is amended by striking subparagraph (A) and inserting the following:

''(A) VESSELS.—In the case of a vessel (other than a vessel described in section 3703a(b) of title 46, United States Code)—

''(i) any person owning, operating, or demise chartering the vessel; and

''(ii) the owner of oil being transported in a tank vessel with a single hull after December 31, 2010, if the owner of the oil knew, or should have known, from publicly available information that the vessel had a poor safety or operational record.''.

TITLE VIII—MARITIME HAZARDOUS CARGO SECURITY

SEC. 801. INTERNATIONAL COMMITTEE FOR THE SAFE AND SECURE TRANSPORTATION OF ESPECIALLY HAZARDOUS CARGO.

(a) IN GENERAL.—Chapter 701 of title 46, United States Code, is amended by inserting after section 70109 the following:

''§ 70109A. International committee for the safe and secure transportation of especially hazardous cargo

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of State and other appropriate entities, shall, in a manner consistent with international treaties, conventions, and agreements to which the United States is a party, establish a committee within the International Maritime Organization that includes representatives of United States trading partners that supply tank or break-bulk shipments of especially hazardous cargo to the United States.

''(b) SAFE AND SECURE LOADING, UNLOADING, AND TRANSPORTATION OF ESPECIALLY HAZARDOUS CARGOES.—In carrying out this section, the Secretary, in cooperation with the International Maritime Organization and in consultation with the International Standards Organization and shipping industry stakeholders, shall develop protocols, procedures, standards, and requirements for receiving, handling, loading, unloading, vessel crewing, and transportation of especially hazardous cargo to promote the safe and secure operation of ports, facilities, and vessels that transport especially hazardous cargo to the United States.

''(c) DEADLINES.—The Secretary shall—

''(1) initiate the development of the committee within 180 days after the date of enactment of the Maritime Hazardous Cargo Security Act; and

''(2) endeavor to have the protocols, procedures, standards, and requirements developed by the committee take effect within 3 years after the date of enactment of that Act.

''(d) REPORTS.—The Secretary shall report annually to the Senate Committee on Commerce, Science, and Transportation, the House of Representatives Committee on Transportation and Infrastructure, and the House of Representatives Committee on Homeland Security on the development, implementation, and administration of the protocols, procedures, standards, and requirements developed by the committee established under subsection (a).''.

(b) CONFORMING AMENDMENT.—The chapter analysis for chapter 701 of title 46, United States Code, is amended by inserting after the item relating the section 70109 the following:

''70109A. International committee for the safe and secure transportation of especially hazardous cargo''.

SEC. 802. VALIDATION OF COMPLIANCE WITH ISPFC STANDARDS.

(a) IN GENERAL.—Chapter 701 of title 46, United States Code, is amended by inserting after section 70110 the following:

''70110A. Port safety and security validations

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of State, shall, in a manner consistent with international treaties, conventions, and agreements to which the United States is a party, develop and implement a voluntary program under which foreign ports and facilities can certify their compliance with applicable International Ship and Port Facility Code standards.

''(b) THIRD-PARTY VALIDATION.—

''(1) IN GENERAL.—In carrying out this section, the Secretary, in cooperation with the International Maritime Organization and the International Standards Organization, shall develop and implement a program under which independent, third-party entities are certified to validate a foreign port's or facility's compliance under the program developed under subsection (a).

''(2) PROGRAM COMPONENTS.—The international program shall include—

''(A) international inspection protocols and procedures;

''(B) minimum validation standards to ensure a port or facility meets the applicable International Ship and Port Facility Code standards;

''(C) recognition for foreign ports or facilities that exceed the minimum standards;

''(D) uniform performance metrics by which inspection validations are to be conducted;

''(E) a process for notifying a port or facility, and its host nation, of areas of concern about the port's or facility's failure to comply with International Ship and Port Facility Code standards;

''(F) provisional or probationary validations;

''(G) conditions under which routine monitoring is to occur if a port or facility receives a provisional or probationary validation;

''(H) a process by which failed validations can be appealed; and

''(I) an appropriate cycle for re-inspection and validation.

''(c) CERTIFICATION OF THIRD PARTY ENTITIES.—The Secretary may not certify a third party entity to validate ports or facilities under subsection (b) unless—

''(1) the entity demonstrates to the satisfaction of the Secretary the ability to perform validations in accordance with the standards, protocols, procedures, and requirements established by the program implemented under subsection (a); and

''(2) the entity has no beneficial interest in or any direct control over the port and facilities being inspected and validated.

''(d) MONITORING—The Secretary shall regularly monitor and audit the operations of each third party entity conducting validations under this section to ensure that it is meeting the minimum standards, operating protocols, procedures, and requirements established by international agreement.

''(e) REVOCATION.—The Secretary shall revoke the certification of any entity determined by the Secretary not to meet the minimum standards, operating protocol, procedures, and requirements established by international agreement for third party entity validations.

''(f) PROTECTION OF SECURITY AND PROPRIETARY INFORMATION.—In carrying out this section, the Secretary shall take appropriate actions to protect from disclosure information that—

''(1) is security sensitive, proprietary, or business sensitive; or

''(2) is otherwise not appropriately in the public domain.

''(g) DEADLINES.—The Secretary shall—

''(1) initiate procedures to carry out this section within 180 days after the date of enactment of the Maritime Hazardous Cargo Security Act; and

''(2) develop standards under subsection (b) for third party validation within 2 years after the date of enactment of that Act.

''(h) REPORTS.—The Secretary shall report annually to the Senate Committee on Commerce, Science, and Transportation, the House of Representatives Committee on Transportation and Infrastructure, and the House of Representatives Committee on Homeland Security on activities conducted pursuant to this section.''.

(c) CONFORMING AMENDMENT.—The chapter analysis for chapter 701 of title 46, United States Code, is amended by inserting after the item relating to section 70110 the following:

''70110A. Port safety and security validations''.

SEC. 803. SAFETY AND SECURITY ASSISTANCE FOR FOREIGN PORTS.

(a) IN GENERAL.—Section 70110(e)(1) of title 46, United States Code, is amended by striking the second sentence and inserting the following: ''The Secretary shall establish a strategic plan to utilize those assistance programs to assist ports and facilities that are found by the Secretary under subsection (a) not to maintain effective antiterrorism measures in the implementation of port security antiterrorism measures.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 70110 of title 46, United States Code, is amended—

(A) by inserting ''**or facilities**'' after ''**ports**'' in the section heading;

(B) by inserting ''or facility'' after ''port'' each place it appears; and

(C) by striking ''PORTS'' in the heading for subsection (e) and inserting ''PORTS, FACILITIES,''.

(2) The chapter analysis for chapter 701 of title 46, United States Code, is amended by striking the item relating to section 70110 and inserting the following:

''70110. Actions and assistance for foreign ports or facilities and United States territories''.

SEC. 804. COAST GUARD PORT ASSISTANCE PROGRAM.

Section 70110 of title 46, United States Code, is amended by adding at the end thereof the following:

''(f) COAST GUARD ASSISTANCE PROGRAM.—

''(1) IN GENERAL.—The Secretary may lend, lease, donate, or otherwise provide equipment, and provide technical training and support, to the owner or operator of a foreign port or facility—

''(A) to assist in bringing the port or facility into compliance with applicable International Ship and Port Facility Code standards;

''(B) to assist the port or facility in meeting standards established under section 70109A of this chapter; and

''(C) to assist the port or facility in exceeding the standards described in subparagraph (A) and (B).

''(2) CONDITIONS.—The Secretary—

''(A) shall provide such assistance based upon an assessment of the risks to the security of the United States and the inability of the owner or operator of the port or facility otherwise to bring the port or facility into compliance with those standards and to maintain compliance with them;

''(B) may not provide such assistance unless the facility or port has been subjected to a comprehensive port security assessment by the Coast Guard or a third party entity certified by the Secretary under section 70110A(b) to validate foreign port or facility compliance with International Ship and Port Facility Code standards; and

''(C) may only lend, lease, or otherwise provide equipment that the Secretary has first determined is not required by the Coast Guard for the performance of its missions.''.

SEC. 805. EHC FACILITY RISK-BASED COST SHARING.

The Commandant shall identify facilities sited or constructed on or adjacent to the navigable waters of the United States that receive, handle, load, or unload especially hazardous cargos that pose a risk greater than an acceptable risk threshold, as determined by the Secretary under a uniform risk assessment methodology. The Secretary may establish a security cost-share plan to assist the Coast Guard in providing security for the transportation of especially hazardous cargo to such facilities.

SEC. 806. TRANSPORTATION SECURITY INCIDENT MITIGATION PLAN.

Section 70103(b)(2) of title 46, United States Code, is amended—

(1) by redesignating subparagraphs (E) through (G) as subparagraphs (F) through (H), respectively; and

(2) by inserting after subparagraph (D) the following:

''(E) establish regional response and recovery protocols to prepare for, respond to, mitigate against, and recover from a transportation security incident consistent with section 202 of the Security and Accountability for Every Port Act of 2006 (6 U.S.C. 942) and section 70103(a) of title 46, United States Code;''.

SEC. 807. INCIDENT COMMAND SYSTEM TRAINING.

The Secretary shall ensure that Federal, State, and local personnel responsible for the safety and security of vessels in port carrying especially hazardous cargo have successfully completed training in the Department of Homeland Security's incident command system protocols.

SEC. 808. PRE-POSITIONING INTEROPERABLE COMMUNICATIONS EQUIPMENT AT INTERAGENCY OPERATIONAL CENTERS.

Section 70107A of title 46, United States Code, is amended—

(1) by redesignating subsections (e) and (f) as subsections (f) and (g), respectively; and

(2) by inserting after subsection (d) the following:

''(e) DEPLOYMENT OF INTEROPERABLE COMMUNICATIONS EQUIPMENT AT INTERAGENCY OPERATIONAL CENTERS.—

''(1) IN GENERAL.—The Secretary shall ensure that interoperable communications

technology is deployed at all interagency operational centers established under subsection (a).

''(2) CONSIDERATIONS.—In carrying out paragraph (1), the Secretary shall consider the continuing technological evolution of communications technologies and devices, with its implicit risk of obsolescence, and shall ensure, to the maximum extent feasible, that a substantial part of the technology deployed involves prenegotiated contracts and other arrangements for rapid deployment of equipment, supplies, and systems rather than the warehousing or storage of equipment and supplies currently available at the time the technology is deployed.

''(3) REQUIREMENTS AND CHARACTERISTICS.—The interoperable communications technology deployed under paragraph (1) shall—

''(A) be capable of re-establishing communications when existing infrastructure is damaged or destroyed in an emergency or a major disaster;

''(B) include appropriate current, widely-used equipment, such as Land Mobile Radio Systems, cellular telephones and satellite equipment, Cells-On-Wheels, Cells-On-Light-Trucks, or other self-contained mobile cell sites that can be towed, backup batteries, generators, fuel, and computers;

''(C) include contracts (including prenegotiated contracts) for rapid delivery of the most current technology available from commercial sources;

''(D) include arrangements for training to ensure that personnel are familiar with the operation of the equipment and devices to be delivered pursuant to such contracts; and

''(E) be utilized as appropriate during live area exercises conducted by the United States Coast Guard.

''(4) ADDITIONAL CHARACTERISTICS.—Portions of the communications technology deployed under paragraph (1) may be virtual and may include items donated on an in-kind contribution basis.

''(5) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed or interpreted to preclude the use of funds under this section by the Secretary for interim or long-term Internet Protocol-based interoperable solutions, notwithstanding compliance with the Project 25 standard.''.

SEC. 809. DEFINITIONS.

In this title:

(1) COMMANDANT.—The term ''Commandant'' means the Commandant of the Coast Guard.

(2) ESPECIALLY HAZARDOUS CARGO.—The term ''especially hazardous cargo'' means any substance identified by the Secretary of the department in which the Coast Guard is operating as especially hazardous cargo.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of the department in which the Coast Guard is operating.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 901. MARINE MAMMALS AND SEA TURTLES REPORT.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of the department in which the Coast Guard is operating shall provide a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure on Coast Guard activities with respect to the protection of marine mammals and sea turtles under United States statutes and international agreements.

(b) REQUIRED CONTENT.—The Secretary shall include in the report, at a minimum—

(1) a detailed summary of actions that the Coast Guard has undertaken annually from fiscal year 2000 through fiscal year 2007 with respect to enforcement efforts, and cooperative agreements and activities with other Federal and State agencies, training programs, and other initiatives;

(2) an annual summary for fiscal year 2000 through fiscal year 2007 by Coast Guard district of the level of effort measured by personnel hours and other available data, for enforcement of the Lacey Act Amendments of 1981 (16 U.S.C. 3371 et seq.), the Endangered Species Act (16 U.S.C. 1531 et seq.), and the Marine Mammal Protection Act (16 U.S.C. 1361 et seq.) as well as international agreements that include provisions on sea turtles or marine mammals to which the United States is a party; and

(3) a summary of any new Coast Guard initiatives for this mission area.

SEC. 902. UMPQUA LIGHTHOUSE LAND CONVEYANCE.

(a) CONVEYANCE AUTHORIZED.—

(1) IN GENERAL.—The Commandant of the Coast Guard may convey to Douglas County, Oregon, all right, title, and interest of the United States in and to the Umpqua Lighthouse property, including improvements thereon, for the purpose of permitting the County to use the property as a park.

(2) PROPERTY DESCRIPTION.—

(A) IN GENERAL.—The Umpqua Lighthouse property is the parcel of approximately 14.81 acres of Coast Guard controlled land located in the NW ¼ of sec. 13, T. 22 S., R. 13 W., Willamette Meridian, and identified as Exhibit A on the aerial map entitled ''U.S. Coast Guard Property at Salmon Harbor/Winchester Bay, Oregon'' dated February 22, 2006.

(B) SURVEYS.—The exact acreage and legal description of the real property to be conveyed under subsections (a) and (c) shall be determined by surveys satisfactory to the Commandant. The cost of the surveys shall be borne by the County.

(b) USE OF PROPERTY CONVEYED.—Notwithstanding section 59.3 of title 36, Code of Federal Regulations (or any successor regulation), and the limitations on the use of land provided assistance under the Land and Water Conservation Fund Act of 1965 (16 U.S.C. 4601-4 et seq.), the real property to be conveyed under this section may be converted to a use other than a public outdoor recreation use.

(c) PROVISION OF REPLACEMENT FACILITIES.—

(1) IN GENERAL.—As consideration for the conveyance authorized by subsection (a), the County—

(A) may, at its expense design and construct the replacement facilities for the Coast Guard to replace the facilities conveyed under that subsection;

(B) may design and construct the replacement facilities to the specifications of the Commandant; and

(C) may construct the replacement facilities upon a parcel of real property determined by the Commandant to be an appropriate location for the replacement facilities; and

(2) shall convey to the United States all right, title, and interest in and to the replacement facilities and the parcel of real property on which the facilities are located.

(d) MEMORANDUM OF AGREEMENT.—The County and the Commandant may enter into a memorandum of agreement to effectuate the transactions authorized by this section.

(e) ADDITIONAL TERMS AND CONDITIONS.—The Commandant may require such additional terms and conditions in connection with the conveyance under subsection (a) as the Commandant considers appropriate to protect the interests of the United States.

(f) LIMITATION.—Nothing in this section compels the County or the Commandant to execute a memorandum of agreement or deed, except upon such terms and conditions that the County and the Commandant may consider appropriate, in the exercise of their discretion, to protect the interests of the County and the United States.

SEC. 903. TRANSFER OF LANDS TO BE HELD IN TRUST.

(a) IN GENERAL.—As soon as practical but not later than 3 years after the date of enactment of this Act, the Commandant of the Coast Guard shall take such actions as are necessary to transfer administrative jurisdiction over lands, including all structures and buildings on lands, depicted on the maps prepared pursuant to subsection (c) of this section to the Secretary of the Interior to hold in trust for the benefit of the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians.

(b) CONDITIONS OF TRANSFER.—

(1) Prior to the transfer of administrative jurisdiction over the lands, the Coast Guard, in its sole discretion, shall execute actions required to comply with applicable environmental and cultural resources law.

(2) Upon such transfer to the Secretary of the Interior, the lands shall be held in trust by the United States for the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians, Oregon, and shall be part of the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw's Reservation.

(c) MAP AND LEGAL DESCRIPTION OF LAND.—

(1) IN GENERAL.—As soon as practicable after the date of enactment of this Act, the Commandant shall file maps entitled ''Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Land Transfer Maps'', which shall depict and provide a legal description of the parcels to be transferred in Coos County, Oregon, totaling approximately 24.0 acres in the areas commonly known as Gregory Point and Chief's Island, with—

(A) the Senate Committee on Commerce, Science, and Transportation;

(B) the House of Representatives Committee on Transportation and Infrastructure; and

(C) the Secretary of the Interior.

(2) FORCE OF LAW.—The maps and legal descriptions filed under paragraph (1) shall have the same force and effect as if included in this Act, except that the Commandant may correct typographical errors in the maps and each legal description.

(3) PUBLIC AVAILABILITY.—Each map and legal description filed under paragraph (1) shall be on file and available for public inspection in the appropriate office of the Department of the Interior.

(d) USE OF COAST GUARD AIDS TO NAVIGATION.—The Coast Guard may retain easements, or other property interests as may be necessary, across the property described in subsection (c) for access to aids to navigation located on the lands so long as such aids may be required by the Coast Guard.

(e) MAINTENANCE OF CAPE ARAGO LIGHT STATION.—

(1) The conveyance of Cape Arago Light Station on Chief's Island by the Coast Guard shall be made on condition that the Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians shall—

(A) use and make reasonable efforts to maintain the Cape Arago Light Station in accordance with the National Historic Preservation Act (16 U.S.C. 470 et seq.), the Secretary of the Interior's Standards for the Treatment of Historic Properties set forth in part 68 of title 36, Code of Federal Regulations, and other applicable laws, and submit any proposed changes to the Cape Arago Light Station for review and approval by the Secretary of the Interior in consultation with the Oregon State Historic Preservation Officer, for consistency with section 800.5(a)(2)(vii) of title 36, Code of Federal Regulations, and the Secretary of the Interior's Standards for Rehabilitation, set forth

in part 67.7 of title 36, Code of Federal Regulations;

(B) make the Cape Arago Light Station available for education, park, recreation, cultural, or historic preservation purposes for the general public at reasonable times and under reasonable conditions;

(C) not sell, convey, assign, exchange, or encumber the Cape Arago Light Station, any part thereof, or any associated historic artifact conveyed in conjunction with the transfer under this section unless such sale, conveyance, assignment, exchange, or encumbrance is approved by Secretary of the Interior;

(D) not conduct any commercial activities at the Cape Arago Light Station, any part thereof, or in connection with any historic artifact conveyed in conjunction with the transfer under this section in any manner, unless such commercial activities are approved by the Secretary of the Interior; and

(E) allow the United States, at any time, to enter the Cape Arago Light Station without notice, for purposes of ensuring compliance with this section, to the extent that it is not possible to provide advance notice.

(2) The Cape Arago Light Station, or any associated historic artifact conveyed in conjunction with the transfer under this section, at the option of the Secretary of the Interior, shall revert to the United States and be placed under the administrative control of the Secretary of the Interior if the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians fail to meet any condition described in paragraph (1).

(f) TRIBAL FISHING RIGHTS.—No fishing right of the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians in existence on the date of enactment of this Act shall be enlarged, impaired, or otherwise affected by the transfer under this section.

SEC. 904. DATA.

In each of fiscal years 2008 through 2010, there are authorized to be appropriated to the Administrator of the National Oceanic and Atmospheric Administration $7,000,000 to acquire through the use of unmanned aerial vehicles data to improve the management of natural disasters, the safety of marine and aviation transportation, and fisheries enforcement.

SEC. 905. EXTENSION.

Section 607 of the Coast Guard and Maritime Transportation Act of 2006 is amended—

(1) by striking ''2007'' in subsection (h) and inserting ''2012''; and

(2) by striking ''terminate'' and all that follows in subsection (i) and inserting ''terminate on September 30, 2012.''.

SEC. 906. FORWARD OPERATING FACILITY.

Not later than 180 days after the date of enactment of this Act, the Secretary of the department in which the Coast Guard is operating may construct or lease hangar, berthing, and messing facilities in the Aleutian Island–Bering Sea operating area. These facilities shall—

(1) support aircraft maintenance, including exhaust ventilation, heat, engine wash system, head facilities, fuel, ground support services, and electrical power; and

(2) shelter for both current helicopter assets and those projected to be located at Air Station Kodiak, Alaska for up to 20 years.

SEC. 907. ENCLOSED HANGAR AT AIR STATION BARBERS POINT, HAWAII.

Not later than 180 days after the date of enactment of this Act, the Secretary of the department in which the Coast Guard is operating may construct an enclosed hangar at Air Station Barbers Point, Hawaii. The hangar shall—

(1) support aircraft maintenance, including exhaust ventilation, heat, engine wash system, head facilities, fuel, ground support services, and electrical power; and

(2) shelter all current aircraft assets and those projected to be located at Air Station Barbers Point, Hawaii, over the next 20 years.

SEC. 908. CONVEYANCE OF DECOMMISSIONED COAST GUARD CUTTER STORIS.

(a) IN GENERAL.—Upon the scheduled decommissioning of the Coast Guard Cutter STORIS, the Commandant of the Coast Guard shall convey, without consideration, all right, title, and interest of the United States in and to that vessel to the USCG Cutter STORIS Museum and Maritime Education Center, LLC, located in the State of Alaska if the recipient—

(1) agrees—

(A) to use the vessel for purposes of a museum and historical display;

(B) not to use the vessel for commercial transportation purposes;

(C) to make the vessel available to the United States Government if needed for use by the Commandant in time of war or a national emergency; and

(D) to hold the Government harmless for any claims arising from exposure to hazardous materials, including asbestos and polychlorinated biphenyls, after conveyance of the vessel, except for claims arising from the use by the Government under subparagraph (C);

(2) has funds available that will be committed to operate and maintain in good working condition the vessel conveyed, in the form of cash, liquid assets, or a written loan commitment and in an amount of at least $700,000; and

(3) agrees to any other conditions the Commandant considers appropriate.

(b) MAINTENANCE AND DELIVERY OF VESSEL.—

(1) MAINTENANCE.—Before conveyance of the vessel under this section, the Commandant shall make, to the extent practical and subject to other Coast Guard mission requirements, every effort to maintain the integrity of the vessel and its equipment until the time of delivery.

(2) DELIVERY.—If a conveyance is made under this section, the Commandant shall deliver the vessel—

(A) at the place where the vessel is located; and

(B) without cost to the Government.

(3) TREATMENT OF CONVEYANCE.—The conveyance of the vessel under this section shall not be considered a distribution in commerce for purposes of section 6(e) of Public Law 94–469 (15 U.S.C. 2605(e)).

(c) OTHER EXCESS EQUIPMENT.—The Commandant may convey to the recipient of a conveyance under subsection (a) any excess equipment or parts from other decommissioned Coast Guard vessels for use to enhance the operability and function of the vessel conveyed under subsection (a) for purposes of a museum and historical display.

SEC. 909. CONVEYANCE OF THE PRESQUE ISLE LIGHT STATION FRESNEL LENS TO PRESQUE ISLE TOWNSHIP, MICHIGAN.

(a) CONVEYANCE OF LENS AUTHORIZED.—

(1) TRANSFER OF POSSESSION.—Notwithstanding any other provision of law, the Commandant of the Coast Guard may transfer to Presque Isle Township, a township in Presque Isle County in the State of Michigan (in this section referred to as the ''Township''), possession of the Historic Fresnel Lens (in this section referred to as the ''Lens'') from the Presque Isle Light Station Lighthouse, Michigan (in this section referred to as the ''Lighthouse'').

(2) CONDITION.—As a condition of the transfer of possession authorized by paragraph (1), the Township shall, not later than one year after the date of transfer, install the Lens in the Lighthouse for the purpose of operating the Lens and Lighthouse as a Class I private aid to navigation pursuant to section 85 of title 14, United States Code, and the applicable regulations under that section.

(3) CONVEYANCE OF LENS.—Upon the certification of the Commandant that the Township has installed the Lens in the Lighthouse and is able to operate the Lens and Lighthouse as a private aid to navigation as required by paragraph (2), the Commandant shall convey to the Township all right, title, and interest of the United States in and to the Lens.

(4) CESSATION OF UNITED STATES OPERATIONS OF AIDS TO NAVIGATION AT LIGHTHOUSE.—Upon the making of the certification described in paragraph (3), all active Federal aids to navigation located at the Lighthouse shall cease to be operated and maintained by the United States.

(b) REVERSION.—

(1) REVERSION FOR FAILURE OF AID TO NAVIGATION.—If the Township does not comply with the condition set forth in subsection (a)(2) within the time specified in that subsection, the Township shall, except as provided in paragraph (2), return the Lens to the Commandant at no cost to the United States and under such conditions as the Commandant may require.

(2) EXCEPTION FOR HISTORICAL PRESERVATION.—Notwithstanding the lack of compliance of the Township as described in paragraph (1), the Township may retain possession of the Lens for installation as an artifact in, at, or near the Lighthouse upon the approval of the Commandant. The Lens shall be retained by the Township under this paragraph under such conditions for the preservation and conservation of the Lens as the Commandant shall specify for purposes of this paragraph. Installation of the Lens under this paragraph shall occur, if at all, not later than two years after the date of the transfer of the Lens to the Township under subsection (a)(1).

(3) REVERSION FOR FAILURE OF HISTORICAL PRESERVATION.—If retention of the Lens by the Township is authorized under paragraph (2) and the Township does not install the Lens in accordance with that paragraph within the time specified in that paragraph, the Township shall return the lens to the Coast Guard at no cost to the United States and under such conditions as the Commandant may require.

(c) CONVEYANCE OF ADDITIONAL PERSONAL PROPERTY.—

(1) TRANSFER AND CONVEYANCE OF PERSONAL PROPERTY.—Notwithstanding any other provision of law, the Commandant may transfer to the Township any additional personal property of the United States related to the Lens that the Commandant considers appropriate for conveyance under this section. If the Commandant conveys the Lens to the Township under subsection (a)(3), the Commandant may convey to the Township any personal property previously transferred to the Township under this subsection.

(2) REVERSION.—If the Lens is returned to the Coast Guard pursuant to subsection (b), the Township shall return to the Coast Guard all personal property transferred or conveyed to the Township under this subsection except to the extent otherwise approved by the Commandant.

(d) CONVEYANCE WITHOUT CONSIDERATION.—The conveyance of the Lens and any personal property under this section shall be without consideration.

(e) DELIVERY OF PROPERTY.—The Commandant shall deliver property conveyed under this section—

(1) at the place where such property is located on the date of the conveyance;

(2) in condition on the date of conveyance; and

(3) without cost to the United States.

(f) MAINTENANCE OF PROPERTY.—As a condition of the conveyance of any property to the Township under this section, the Commandant shall enter into an agreement with the Township under which the Township agrees—

(1) to operate the Lens as a Class I private aid to navigation under section 85 of title 14, United States Code, and application regulations under that section; and

(2) to hold the United States harmless for any claim arising with respect to personal property conveyed under this section.

(g) LIMITATION ON FUTURE CONVEYANCE.—The instruments providing for the conveyance of property under this section shall—

(1) require that any further conveyance of an interest in such property may not be made without the advance approval of the Commandant; and

(2) provide that, if the Commandant determines that an interest in such property was conveyed without such approval—

(A) all right, title, and interest in such property shall revert to the United States, and the United States shall have the right to immediate possession of such property; and

(B) the recipient of such property shall pay the United States for costs incurred by the United States in recovering such property.

(h) ADDITIONAL TERMS AND CONDITIONS.—The Commandant may require such additional terms and conditions in connection with the conveyances authorized by this section as the Commandant considers appropriate to protect the interests of the United States.

SEC. 910. REPEALS.

The following sections are repealed:

(1) Section 689 of title 14, United States Code, and the item relating to such section in the analysis for chapter 18 of such title.

(2) Section 216 of title 14, United States Code, and the item relating to such section in the analysis for chapter 11 of such title.

SEC. 911. REPORT ON SHIP TRAFFIC.

(a) REPORT.—No later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of the department in which the Coast Guard is operating shall provide a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure on the volume of foreign flag ships entering waters subject to the jurisdiction of the United States. The report may be submitted in classified format if the Secretary deems it to be necessary for national security.

(b) CONTENTS.—The report shall include a breakdown of the number or percentage of such foreign flag ships that—

(1) enter a United States port or place;

(2) do not enter a United States port or place but pass through the territorial sea of the United States; or

(3) do not enter a United States port or place but pass only through the exclusive economic zone of the United States.

(c) DEFINITIONS.—In this section:

(1) EXCLUSIVE ECONOMIC ZONE.—The term ''exclusive economic zone'' means the Exclusive Economic Zone of the United States established by Proclamation Number 5030, dated March 10, 1983 (16 U.S.C. 1453 note).

(2) TERRITORIAL SEA.—The term ''territorial sea'' means the waters of the Territorial Sea of the United States under Presidential Proclamation 5928, dated December 27, 1988 (43 U.S.C. 1331 note).

SEC. 912. SMALL VESSEL EXCEPTION FROM DEFINITION OF FISH PROCESSING VESSEL.

Section 2101(11b) of title 46, United States Code, is amended by striking ''chilling.'' and inserting ''chilling, but does not include a fishing vessel operating in Alaskan waters under a permit or license issued by Alaska that—

(A) fillets only salmon taken by that vessel;

(B) fillets less than 5 metric tons of such salmon during any 7-day period.''.

SEC. 913. RIGHT OF FIRST REFUSAL FOR COAST GUARD PROPERTY ON JUPITER ISLAND, FLORIDA.

(a) RIGHT OF FIRST REFUSAL.—Notwithstanding any other law (other than this section), the Town of Jupiter Island, Florida, shall have the right of first refusal to select and take without consideration fee simple title to real property within the jurisdiction of the Town comprising Parcel #35-38-42-004-000-02590-6 (Bon Air Beach lots 259 and 260 located at 83 North Beach Road) and Parcel #35-38-42-004-000-02610-2 (Bon Air Beach lots 261 to 267), including any improvements thereon that are not authorized or required by another provision of law to be conveyed to another person.

(b) IDENTIFICATION OF PROPERTY.—The Commandant of the Coast Guard may identify, describe, and determine the property referred to in subsection (a) that is subject to the right of the Town under that subsection.

(c) LIMITATION.—The property referred to in subsection (a) may not be conveyed under that subsection until the Commandant of the Coast Guard determines that the property is not needed to carry out Coast Guard operations.

(d) REQUIRED USE.—Any property conveyed under this section shall be used by the Town of Jupiter Island, Florida, solely for conservation of habitat and as protection against damage from wind, tidal, and wave energy.

(e) REVERSION.—Any conveyance of property under this section shall be subject to the condition that all right, title, and interest in the property, at the option of the Commandant of the Coast Guard, shall revert to the United States Government if the property is used for purposes other than conservation.

(f) IMPLEMENTATION.—The Commandant of the Coast Guard shall upon request by the Town—

(1) promptly take those actions necessary to make property identified under subsection (b) and determined by the Commandant under subsection (c) ready for conveyance to the Town; and

(2) convey the property to the Town subject to subsections (d) and (e).

SEC. 914. SHIP DISPOSAL WORKING GROUP.

(a) IN GENERAL.—Within 30 days after the date of enactment of this Act, the Secretary of Transportation shall convene a working group, composed of senior representatives from the Maritime Administration, the Coast Guard, the Environmental Protection Agency, the National Oceanic and Atmospheric Administration, and the United States Navy. The Secretary may request the participation of senior representatives of any other Federal department or agency, as appropriate, and shall consult with appropriate State environmental agencies. The working group shall review and make recommendations on environmental practices for the storage and disposal of obsolete vessels owned or operated by the Federal Government.

(b) SCOPE.—Among the vessels to be considered by the working group are Federally owned or operated vessels that are—

(A) to be scrapped or recycled;

(B) to be used as artificial reefs; or

(C) to be used for the Navy's SINKEX program.

(c) PURPOSE.—The working group shall—

(1) examine current storage and disposal policies, procedures, and practices for obsolete vessels owned or operated by Federal agencies;

(2) examine Federal and State laws and regulations governing such policies, procedures, and practices and any applicable environmental laws; and

(3) within 90 days after the date of enactment of this Act, submit a plan to the Senate Committee on Commerce, Science, and Transportation, the Senate Committee on Environment and Public Works, and the House of Representatives Committee on Armed Services to improve and harmonize practices for storage and disposal of such vessels, including the interim transportation of such vessels.

(d) CONTENTS OF PLAN.—The working group shall include in the plan submitted under subsection (c)(3)—

(1) a description of existing measures for the storage, disposal, and interim transportation of obsolete vessels owned or operated by Federal agencies in compliance with Federal and State environmental laws in a manner that protects the environment;

(2) a description of Federal and State laws and regulations governing current policies, procedures, and practices for the storage, disposal, and interim transportation of such vessels;

(3) recommendations for environmental best practices that meet or exceed, and harmonize, the requirements of Federal environmental laws and regulations applicable to the storage, disposal, and interim transportation of such vessels;

(4) recommendations for environmental best practices that meet or exceed the requirements of State laws and regulations applicable to the storage, disposal, and interim transportation of such vessels;

(5) procedures for the identification and remediation of any environmental impacts caused by the storage, disposal, and interim transportation of such vessels; and

(6) recommendations for necessary steps, including regulations if appropriate, to ensure that best environmental practices apply to all such vessels.

(e) IMPLEMENTATION OF PLAN.—

(1) IN GENERAL.—As soon as practicable after the date of enactment of this Act, the head of each Federal department or agency participating in the working group, in consultation with the other Federal departments and agencies participating in the working group, shall take such action as may be necessary, including the promulgation of regulations, under existing authorities to ensure that the implementation of the plan provides for compliance with all Federal and State laws and for the protection of the environment in the storage, interim transportation, and disposal of obsolete vessels owned or operated by Federal agencies.

(2) ARMED SERVICES VESSELS.—The Secretary and the Secretary of Defense, in consultation with the Administrator of the Environmental Protection Agency, shall each ensure that environmental best practices are observed with respect to the storage, disposal, and interim transportation of obsolete vessels owned or operated by the Department of Defense.

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to supersede, limit, modify, or otherwise affect any other provision of law, including environmental law.

SEC. 915. FULL MULTI-MISSION RESPONSE STATION IN VALDEZ, ALASKA.

Not later than 180 days after the date of enactment of this Act, the Secretary of the department in which the Coast Guard is operating may construct a full multi-mission Coast Guard Response Station in Valdez, Alaska. The Station shall include shore and

maintenance infrastructure facilities to support all current and projected Coast Guard waterborne security forces to be located in Valdez, Alaska, over the next 20 years.

SEC. 916. PROTECTION AND FAIR TREATMENT OF SEAFARERS.

(a) IN GENERAL.—Chapter 5 of title 14, United States Code, is amended by inserting after section 89 the following:

"§ 89a. Protection and fair treatment of seafarers

''(a) AUTHORITY OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary is authorized—

''(A) to require a bond or surety satisfactory as an alternative to withholding or revoking clearance required under section 60105 of title 46 if, in the opinion of the Secretary, such bond or surety satisfactory is necessary to facilitate an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard, provided that corporate sureties underwriting any such bonds be certified by the Department of the Treasury to write Federal bonds under sections 9304 and 9305 of title 31;

''(B) at the discretion of the Secretary, to pay, in whole or in part, without further appropriation and without fiscal year limitation, from amounts in the Fund, necessary support of—

''(i) any seafarer who enters, remains, or has been paroled into the United States and is involved in an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard; and

''(ii) any seafarer whom the Secretary finds to have been abandoned in the United States; and

''(C) at the sole discretion of the Secretary, to reimburse, in whole or in part, without further appropriation and without fiscal year limitation, from amounts in the Fund, a shipowner, who has filed a bond or surety satisfactory pursuant to subparagraph (A) of this paragraph and provided necessary support of a seafarer who has been paroled into the United States to facilitate an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard, for costs of necessary support, when the Secretary deems reimbursement necessary to avoid serious injustice.

''(2) APPLICATION.—The authority to require a bond or a surety satisfactory or to request the withholding or revocation of the clearance required under section 60105 of title 46 is applicable to any investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard.

''(3) LIMITATIONS.—Nothing in this section shall be construed—

''(A) to create a right, benefit, or entitlement to necessary support; or

''(B) to compel the Secretary to pay, or reimburse the cost of, necessary support.

''(b) FUND.—

''(1) IN GENERAL.—There is established in the Treasury a special fund known as the 'Support of Seafarers Fund'.

''(2) AVAILABILITY.—The amounts covered into the Fund shall be available to the Secretary, without further appropriation and without fiscal year limitation—

''(A) to pay necessary support, pursuant to subsection (a)(1)(B) of this section; and

''(B) to reimburse a shipowner for necessary support, pursuant to subsection (a)(1)(C) of this section.

''(3) RECEIPTS.—Notwithstanding any other provision of law, the Fund shall be authorized to receive—

''(A) amounts reimbursed or recovered pursuant to subsection (c) of this section;

''(B) amounts appropriated to the Fund pursuant to subsection (f) of this section; and

''(C) appropriations available to the Secretary for transfer.

''(4) LIMITATION ON CERTAIN CREDITS.—The Fund may receive credits pursuant to paragraph (3)(A) of this subsection only when the unobligated balance of the Fund is less than $5,000,000.

''(5) REPORT REQUIRED.—

''(A) Except as provided in subparagraph (B) of this paragraph, the Secretary shall not obligate any amount in the Fund in a given fiscal year unless the Secretary has submitted to Congress, concurrent with the President's budget submission for that fiscal year, a report that describes—

''(i) the amounts credited to the Fund, pursuant to paragraph (3) of this section, for the preceding fiscal year;

''(ii) a detailed description of the activities for which amounts were charged; and

''(iii) the projected level of expenditures from the Fund for the coming fiscal year, based on—

''(I) on-going activities; and

''(II) new cases, derived from historic data.

''(B) The limitation in subparagraph (A) of this paragraph shall not apply to obligations during the first fiscal year during which amounts are credited to the Fund.

''(6) FUND MANAGER.—The Secretary shall designate a Fund manager, who shall—

''(A) ensure the visibility and accountability of transactions utilizing the Fund;

''(B) prepare the report required pursuant to paragraph (5) of this subsection; and

''(C) monitor the unobligated balance of the Fund and provide notice to the Secretary and the Attorney General whenever the unobligated balance of the Fund is less than $5,000,000.

''(c) REIMBURSEMENTS—

''(1) RECOVERY.—Any shipowner—

''(A)(i) who, during the course of an investigation, reporting, documentation, or adjudication of any matter that the Coast Guard referred to a United States Attorney or the Attorney General, fails to provide necessary support of a seafarer who has been paroled into the United States to facilitate the investigation, reporting, documentation, or adjudication, and

''(ii) against whom a criminal penalty is subsequently imposed, or

''(B) who, under any circumstance, abandons a seafarer in the United States, as determined by the Secretary,

shall reimburse the Fund an amount equal to the total amount paid from the Fund for necessary support of the seafarer, plus a surcharge of 25 per cent of such total amount.

''(2) ENFORCEMENT.—If a shipowner fails to reimburse the Fund as required under paragraph (1) of this subsection, the Secretary may—

''(A) proceed in rem against any vessel of the shipowner in the Federal district court for the district in which such vessel is found; and

''(B) withhold or revoke the clearance, required by section 60105 of title 46, of any vessel of the shipowner wherever such vessel is found.

''(3) CLEARANCE.—Whenever clearance is withheld or revoked pursuant to paragraph (2)(B) of this subsection, clearance may be granted if the shipowner reimburses the Fund the amount required under paragraph (1) of this subsection.

''(d) DEFINITIONS.—In this section:

''(1) ABANDONS; ABANDONED.—The term 'abandons' or 'abandoned' means a shipowner's unilateral severance of ties with a seafarer or the shipowner's failure to provide necessary support of a seafarer;

''(2) BOND OR SURETY SATISFACTORY.—The term 'bond or surety satisfactory' means a negotiated instrument, the terms of which may, at the discretion of the Secretary, include provisions that require the shipowner to—

''(A) provide necessary support of a seafarer who has or may have information pertinent to an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard;

''(B) facilitate an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard;

''(C) stipulate to certain incontrovertible facts, including, but not limited to, the ownership or operation of the vessel, or the authenticity of documents and things from the vessel;

''(D) facilitate service of correspondence and legal papers;

''(E) enter an appearance in Federal district court;

''(F) comply with directions regarding payment of funds;

''(G) name an agent in the United States for service of process;

''(H) make stipulations as to the authenticity of certain documents in Federal district court;

''(I) provide assurances that no discriminatory or retaliatory measures will be taken against a seafarer involved in an investigation, reporting, documentation, or adjudication of any matter that is related to the administration or enforcement of any treaty, law, or regulation by the Coast Guard;

''(J) provide financial security in the form of cash, bond, or other means acceptable to the Secretary; and

''(K) provide for any other appropriate measures as the Secretary deems necessary to ensure the Government is not prejudiced by granting the clearance required by section 60105 of title 46.

''(3) FUND.—The term 'Fund' means the Support of Seafarers Fund, established by subsection (b);

''(4) NECESSARY SUPPORT.—The term 'necessary support' means normal wages, lodging, subsistence, clothing, medical care (including hospitalization), repatriation, and any other expense the Secretary deems appropriate;

''(5) SEAFARER.—The term 'seafarer' means an alien crewman who is employed or engaged in any capacity on board a vessel subject to the jurisdiction of the United States;

''(6) SHIPOWNER.—The term 'shipowner' means the individual or entity that owns, has an ownership interest in, or operates a vessel subject to the jurisdiction of the United States;

''(7) VESSEL SUBJECT TO THE JURISDICTION OF THE UNITED STATES.—The term 'vessel subject to the jurisdiction of the United States' has the same meaning it has in section 70502(c) of title 46, except that it excludes a vessel owned or bareboat chartered and operated by the United States, by a State or political subdivision thereof, or by a foreign nation, except when such vessel is engaged in commerce.

''(e) REGULATIONS.—The Secretary is authorized to promulgate regulations to implement this subsection.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to

the Fund $1,500,000 for each of fiscal years 2009, 2010, and 2011.''.

(b) CLERICAL AMENDMENT.—The chapter analysis for chapter 5 of such title is amended by inserting after the item relating to section 89 the following:

''89a. Protection and fair treatment of seafarers''.

SEC. 917. ICEBREAKERS.

(a) IN GENERAL.—The Secretary of the department in which the Coast Guard is operating shall acquire or construct 2 polar icebreakers for operation by the Coast Guard in addition to its existing fleet of polar icebreakers.

(b) NECESSARY MEASURES.—The Secretary shall take all necessary measures, including the provision of necessary operation and maintenance funding, to ensure that—

(1) the Coast Guard maintains, at a minimum, its current vessel capacity for carrying out ice breaking in the Arctic and Antarctic, Great Lakes, and New England regions; and

(2) any such vessels that are not fully operational are brought up to, and maintained at full operational capability.

(c) REIMBURSEMENT.—Nothing in this section shall preclude the Secretary from seeking reimbursement for operation and maintenance costs of such polar icebreakers from other Federal agencies and entities, including foreign countries, that benefit from the use of the icebreakers.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2008 to the Secretary of the department in which the Coast Guard is operating such sums as may be necessary to acquire the icebreakers authorized by subsection (a), as well as maintaining and operating the icebreaker fleet as authorized in subsection (b).

SEC. 918. FUR SEAL ACT AUTHORIZATION.

Section 206(c)(1) of the Fur Seal Act of 1966 (16 U.S.C. 1166(c)(1)) is amended by striking ''and 2007'' and inserting ''2007, 2008, and 2009''.

SEC. 919. STUDY OF RELOCATION OF COAST GUARD SECTOR BUFFALO FACILITIES.

(a) PURPOSES.—The purposes of this section are—

(1) to authorize a project study to evaluate the feasibility of consolidating and relocating Coast Guard facilities at Coast Guard Sector Buffalo within the study area;

(2) to obtain a preliminary plan for the design, engineering, and construction for the consolidation of Coast Guard facilities at Sector Buffalo; and

(3) to distinguish what Federal lands, if any, shall be identified as excess after the consolidation.

(b) DEFINITIONS.—In this section:

(1) COMMANDANT.—The term ''Commandant'' means the Commandant of the Coast Guard.

(2) SECTOR BUFFALO.—The term ''Sector Buffalo'' means Coast Guard Sector Buffalo of the Ninth Coast Guard District.

(3) STUDY AREA.—The term ''study area'' means the area consisting of approximately 31 acres of real property and any improvements thereon that are commonly identified as Coast Guard Sector Buffalo, located at 1 Fuhrmann Boulevard, Buffalo, New York, and under the administrative control of the Coast Guard.

(c) STUDY.—

(1) IN GENERAL.—Within 12 months after the date on which funds are first made available to carry out this section, the Commandant shall conduct a project proposal report of the study area and shall submit such report to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives.

(2) REQUIREMENTS.—The project proposal report shall—

(A) evaluate the most cost-effective method for providing shore facilities to meet the operational requirements of Sector Buffalo;

(B) determine the feasibility of consolidating and relocating shore facilities on a portion of the existing site, while—

(i) meeting the operational requirements of Sector Buffalo; and

(ii) allowing the expansion of operational requirements of Sector Buffalo; and

(C) contain a preliminary plan for the design, engineering, and construction of the proposed project, including—

(i) the estimated cost of the design, engineering, and construction of the proposed project;

(ii) an anticipated timeline of the proposed project; and

(iii) a description of what Federal lands, if any, shall be considered excess to Coast Guard needs.

(d) LIMITATION.—Nothing in this section shall affect the current administration and management of the study area.

SEC. 920. INSPECTOR GENERAL REPORT ON COAST GUARD DIVE PROGRAM.

(a) INSPECTOR GENERAL REPORT.—Within 1 year after the date of enactment of this Act, the Inspector General of the Department of Homeland Security shall submit a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Transportation and Infrastructure on the circumstances surrounding the accidental death of Coast Guard crew members on a training dive while serving aboard the Coast Guard icebreaker HEALY on August 17, 2006. The Inspector General shall include in the report—

(1) a description of programmatic changes made by the Coast Guard in its dive program in response to the accident;

(2) an evaluation of whether those changes are effective and are sufficient to prevent similar accidents; and

(3) recommendations for further improvement in the safety of the dive program.

(b) HILL-DUQUE COAST GUARD DIVE PROGRAM REPORT.—Within 6 months after the date of enactment of this Act, the Inspector General shall submit an interim report to the Committees describing the progress made in preparing the report required by subsection (a).

Ms. SNOWE. Mr. President, as Ranking Member on the Coast Guard's oversight subcommittee, I am pleased today to co-sponsor the Coast Guard Authorization Act for fiscal year 2008.

The Coast Guard serves as the guardian of our maritime homeland security and provides many critical services for our nation. Last year alone, the Coast Guard responded to over 28,000 calls for assistance, and saved nearly 5,300 lives. These brave men and women risk their lives to defend our borders from drugs, illegal immigrants, acts of terror, and other national security threats. In 2004, the Coast Guard seized 287,000 pounds of cocaine, including over 20 tons in a single interdiction action, the largest drug bust ever recorded. They also stopped nearly 8,000 illegal migrants from reacting our shores. In addition they conducted 6,100 boardings to protect our vital fisheries stocks and they responded to 4,400 pollution incidents.

In today's post-9/11 world, the men and women of the Coast Guard have been working harder than ever securing the nation's coastline, waterways, and ports. This rapid escalation of the Coast Guard's homeland security mission catalogue continues today. While our new reality requires the Coast Guard to maintain a robust homeland security posture, these new priorities must not diminish the Coast Guard's focus on its traditional missions such as marine safety, search and rescue, aids to navigation, fisheries law enforcement, and marine environmental protection.

The bill we introduce today would authorize funding at $8.3 billion for fiscal year 2008. This authorization will continue to allow the Coast Guard to perform non-homeland security missions such as search and rescue, fisheries enforcement, and marine environmental protection, as well as fund the necessary missions related to ports, waterways, and coastal security. It also includes funding to allow the service to continue replacing its rapidly aging assets so it can increase efficiency of its actions and reap the benefits of advances of modern technology and engineering.

The Coast Guard's rapid operational escalation has taken a significant toll on the ships, boats, and aircraft that the Coast Guard uses on a daily basis, putting additional strain on vessels that already collectively comprise the world's third oldest navel fleet. The Coast Guard is now 5 years into the acquisition phase of a program designed to recapitalize its aging infrastructure the Integrated Deepwater Program. In recent months, we have heard a litany of bad news regarding Deepwater, from the decommissioning of eight 123-foot patrol boats following a failed effort to extend them, to reports that Deepwater's flagship, the National Security Cutter, will not meet the specifications required by the Coast Guard. The service has taken numerous steps to rectify contractual shortcomings that have led to many of these problems, but much work remains to be done before the Coast Guard can regain the confidence of its overseers and the American public. This bill authorizes nearly $1 billion for Coast Guard acquisitions programs, a large sum to be sure. But Senator CANTWELL and I, and the rest of the Coast Guard's oversight subcommittee will closely monitor developments with the program to ensure that the mistakes of Deepwater's past are not carried over into its future.

This bill also includes a provision to increase the Coast Guard's ability to prosecute those engaged in illegal alien smuggling in the maritime environment. Under current law and practice, individuals have to be seriously injured or die in a maritime migrant smuggling event before the smugglers are faced with meaningful legal penalties. This allows organized groups of experienced smugglers to operate with near impunity, facilitating the entry of

thousands of illegal immigrants annually. The Maritime Alien Smuggling Law Enforcement Act, contained within this bill would close this serious loophole at the frontline of our homeland security efforts.

The bill also contains provisions vital to navigation security, including a requirement that the Coast Guard continue to operate the LORAN–C navigation system. Though advances in Global Positioning System technology have allowed our mariners to receive accurate, timely positioning data, many seafarers, particularly in the northern latitudes where GPS signals are less strong, still rely on LORAN signals as a back-up to their more modern systems, or in some cases, as a primary navigation aid.

The service men and women of the Coast Guard do yeoman's work in support of our homeland security and to ensure the safety of the maritime domain, and this bill also contains provisions to help them in numerous ways. Provisions ensure the Government is providing adequate access to medical care for those stationed on remote islands; grants Coast Guard servicemen and women access to the armed forces retirement homes; and authorizes funding for additional facilities to improve their quality of life.

In sum, this bill contains provisions too numerous to mention individually that support the Coast Guard's missions and enhance its ability to safeguard our homeland, our environment, and our maritime operations. I thank Senator CANTWELL and the rest of my fellow co-sponsors for all their hard work on this bill, and I ask my colleagues in this body to join me in expressing support for the valiant men and women of the Coast Guard and this bill that will facilitate execution of their appointed missions.

By Mr. BAUCUS:

S. 1893. An original bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; from the Committee on Finance; placed on the calendar.

Mr. BAUCUS. Mr. President, I ask unanimous consent the following material regarding today's introduction of S. 1893, the Children's Health Insurance Program Reauthorization Act of 2007, be included in the RECORD, July 26, 2007 letter from the Congressional Budget Office; and Technical Summary of the Children's Health Insurance Program Reauthorization Act of 2007.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 26, 2007.

Hon. MAX BAUCUS,
Chairman Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared the attached cost estimate for the Children's Health Insurance Program Reauthorization Act of 2007, based on the legislative language (ERN07632) that was provided by the Committee on Finance on July 26, 2007.

CBO estimates that enacting this legislation would increase federal direct spending by $35.2 billion over the 2008–2012 period and by $71.0 billion over the 2008–2017 period. CBO and JCT estimate that net revenues would increase under the bill by $36.1 billion over the next five years and $72.8 billion over the 10-year period. A portion of that increase would be in off-budget revenues: $0.8 billion for the 2008–2012 period and $1.1 billion over the 2008–2017 period. On balance, the spending and revenue changes would reduce federal on-budget deficits by $0.1 billion through 2012 and $0.8 billion for the 2008–2017 period. The two attached tables provide estimates of year-by-year changes and a summary of the estimated change in enrollment of children under the State Children's Health Insurance Program (SCHIP) and Medicaid.

Projected spending would exceed estimated on-budget revenue increases beginning in fiscal year 2015. Pursuant to section 203 of S. Con. Res. 21, the Concurrent Resolution on the Budget for Fiscal Year 2008, CBO estimates that the changes in direct spending and revenues would cause an increase in the on-budget deficit greater than $5 billion in at least one of the 10-year periods between 2018 and 2057.

CBO has reviewed the non-tax provisions of the bill—titles I through VI, excluding section 411, and title VII—for mandates and determined that they contain no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would affect the way states administer SCHIP and Medicaid, but because of the flexibility in those programs, the new requirements would not be intergovernmental mandates as UMRA defines that term. In general, state, local, and tribal governments would benefit from the continuation of existing SCHIP grants, the creation of new grant programs, and broader flexibility and options in some programs.

According to JCT, the tax provisions of the bill contain no intergovernmental mandates as defined in UMRA. JCT has determined that the tax provisions of the bill contain a private-sector mandate, as defined in UMRA, by increasing the excise tax rate on cigarettes and other tobacco products. The costs of that mandate would be similar to the estimated budget effects of the provision (as shown in the attached table), and thus would significantly exceed the threshold established in UMRA for private-sector mandates in each year (the threshold is $131 million in 2007, and is adjusted annually for inflation).

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Eric Rollins and Jeanne De Sa.

Sincerely,

PETER R. ORSZAG,
Director.

CBO'S ESTIMATE OF THE EFFECTS ON DIRECT SPENDING AND REVENUES OF THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

[Based on the legislative language ERN07632, provided by the Senate Committee on Finance on July 26, 2007]

Figures are outlays, by fiscal year, in billions of dollars. Costs or savings of less than $50 million are shown with an asterisk. Components may not sum to totals because of rounding.

Section	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–12	2008–17
CHANGES IN DIRECT SPENDING												
SCHIP outlays from the funding provided in sections 101, 103, 104, and 105 of the bill:												
Benefits and administration costs	2.2	3.8	5.5	6.5	7.4	−0.4	−1.8	−1.8	−1.7	−1.6	25.4	18.1
Incentive payments	0	0.4	0.6	0.8	0.9	1.0	1.1	1.2	1.2	1.3	2.7	8.4
Subtotal	2.2	4.1	6.1	7.2	8.4	0.6	−0.7	−0.6	−0.4	−0.3	28.1	26.5
Medicaid outlays due to interactions with the SCHIP outlays shown above	−0.3	0.3	1.2	1.6	1.8	4.5	6.0	7.1	7.7	8.4	4.7	38.4
Other changes in direct spending that are not included with the SCHIP and Medicaid totals above:												
104 Additional administrative funding for territories	*	*	*	*	*	*	*	*	*	*	0.1	0.1
105 Funding for improved reporting of Medicaid enrollment	*	*	0	0	0	0	0	0	0	0	*	*
108 Contingency fund	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	1.1
201 Grants for outreach and enrollment	*	*	*	*	0.1	*	*	*	*	*	0.2	0.4
203 Express Lane demonstration project	*	*	*	*	*	0	0	0	0	0	*	*
301 Revise requirement to document citizenship	0	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.6	1.4	3.7
501 Development of quality measures for child health	*	0.1	0.1	0.1	0.1	*	*	*	*	*	0.3	0.4
604 Additional funding for Current Population Survey	*	*	*	*	*	*	*	*	*	*	0.1	0.1
608 Dental health grants	*	0.1	0.1	0.1	*	0	0	0	0	0	0.2	0.2
609 Transition grants for payment of FQHC / RHC services	*	*	0	0	0	0	0	0	0	0	*	*
Subtotal	0.1	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	2.4	6.1
Total changes in direct spending	2.1	5.0	7.9	9.4	10.8	5.8	6.0	7.2	8.0	8.9	35.2	71.0
CHANGES IN REVENUES												
On-budget revenues:												
701 Increased taxes on tobacco products	6.2	7.6	7.4	7.3	7.3	7.2	7.1	7.1	7.0	6.9	35.7	71.1
703 Changed timing of corporate estimated tax payments	0	0	0	0	−0.9	−0.9	0	0	0	0	−0.9	0
Effect of SCHIP provisions on on-budget revenues	*	0.1	0.1	0.1	0.1	0.1	*	*	*	*	0.5	0.7
Subtotal	6.2	7.7	7.5	7.4	6.5	8.2	7.2	7.1	7.0	7.0	35.3	71.7
Off-budget revenues (due to SCHIP provisions)	0.1	0.2	0.2	0.2	0.2	0.1	*	*	*	0.1	0.8	1.1
Total changes in revenues	6.3	7.8	7.7	7.6	6.7	8.3	7.2	7.1	7.1	7.0	36.1	72.8
Net budgetary effect of legislation:												
Direct spending and on-budget revenues	−4.2	−2.7	0.4	2.0	4.3	−2.4	−1.2	0.1	1.0	1.9	−0.1	−0.8
Direct spending and all revenues	−4.3	−2.8	0.2	1.3	4.1	−2.5	−1.2	*	0.9	1.8	−0.9	−1.8
Memorandum:												
SCHIP outlays under CBO's baseline	5.4	5.4	5.5	5.5	5.6	5.5	5.3	5.3	5.2	5.1	27.4	53.8
Additional SCHIP outlays under proposal	2.3	4.3	6.2	7.4	8.5	0.7	−0.6	−0.5	−0.3	−0.2	28.6	27.9
Total SCHIP outlays under proposal	7.7	9.7	11.7	12.9	14.1	6.2	4.7	4.8	4.9	5.0	56.1	81.7

CBO's ESTIMATE OF CHANGES IN SCHIP AND MEDICAID ENROLLMENT OF CHILDREN UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

(Based on the legislative language ERN07632, provided by the Senate Committee on Finance on July 26, 2007)

All figures are average monthly enrollment, in millions of individuals. Components may not sum to totals because of rounding.

	SCHIP [a]				Medicaid [b]				SCHIP/Medicaid total		
	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Reduction in the uninsured	Reduction in private coverage	Total
Fiscal Year 2012:											
CBO's baseline projections				3.3				25.0			28.3
Effect of providing funding to maintain current SCHIP programs	0.6	0.8	0.5	1.9	−0.6	n.a.	n.a.	−0.6	0.8	0.5	1.3
Effect of additional SCHIP funding and other provisions:											
Additional enrollment within existing eligibility groups [c,d]	n.a.	0.9	0.6	1.5	n.a.	1.7	0.4	2.2	2.7	1.0	3.7
Expansion of SCHIP eligibility to new populations	n.a.	0.6	0.6	1.1	n.a.	n.a.	n.a.	n.a.	0.6	0.6	1.1
Subtotal	n.a.	1.5	1.2	2.6	n.a.	1.7	0.4	2.2	3.2	1.6	4.8
Total proposed changes	0.6	2.2	1.7	4.5	−0.6	1.7	0.4	1.5	4.0	2.1	6.1
Estimated enrollment under proposal				7.9				26.5			34.4

Notes:

[a] The figures in this table include the program's adult enrollees, who account for less than 10 percent of total SCHIP enrollment.

[b] The figures in this table do not include children who receive Medicaid because they are disabled.

[c] For simplicity of display, the Medicaid figures in this line include the additional children enrolled as a side effect of expansions of SCHIP eligibility.

[d] The Medicaid figures and SCHIP/Medicaid totals in this line include about 100,000 adults who would gain eligibility under section 301 of the bill.

n.a. = not applicable

TECHNICAL SUMMARY OF THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES; TABLE OF CONTENTS

Current Law

No provision.

Explanation of Provision

This act may be cited as the ''Children's Health Insurance Program (CHIP) Reauthorization Act of 2007.'' Unless otherwise noted, this act amends, or repeals provisions of the Social Security Act. When this act references: ''CHIP'' it is referring to the State Children's Health Insurance Program established under Title XXI; ''MEDICAID'' it is referring to the program for medical assistance established under title XIX; ''Secretary'' it is referring to the Secretary of Health and Human Services.

Title I—Financing of CHIP

SECTION 101. EXTENSION OF CHIP

Current Law

Title XXI of the Social Security Act specifies the following national appropriation amounts in §2104(a) from FY 1998 to FY2007 for SCHIP:

$4,295,000,000 in FY1998;
$4,275,000,000 in FY 1999;
$4,275,000,000 in FY2000;
$4,275,000,000 in FY 2001;
$3,150,000,000 in FY 2002;
$3,150,000,000 in FY2003;
$3,150,000,000 in FY2004;
$4,050,000,000 in FY2005;
$4,050,000,000 in FY2006; and
$5,000,000,000 in FY2007.

These amounts are alloted to states, including the District of Columbia, except for (1) 0.25% of the total annual amount is alloted to the territories and commonwealths (hereafter referred to simply as ''the territories''), and (2) from FY1998 to FY2002, $60 million was set aside annually for special diabetes grants (Public Health Service Act §330B and §330C), which are now funded by direct appropriations. the territories are also alloted the following appropriation amounts in §2104(c)(4)(B):

$32,000,000 in FY1999;
$34,200,000 in FY2000;
$34,200,000 in FY2001;
$25,200,000 in FY2002;
$25,200,000 in FY2003;
$25,200,000 in FY2004;
$32,400,000 in FY2005;
$32,400,000 in FY2006; and
$40,000,000 in FY2007.

Explanation of Provision

The following national appropriation amounts are specified for CHIP in §2104(a):

$9,125,000,000 in FY 2008;
$10,675,000,000 in FY2009;
$11,850,000,000 in FY 2010;
$13,750,000,000 in FY 2001; and
$3,500,000,000 in FY2012.

SECTION 102. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA

Current Law

The annual SCHIP appropriation available to states, including the District of Columbia, is the amount of the total appropriation remaining after amounts set aside for the territories and, for FY1998 to FY2002, the special diabetes grants. Each state's share, or percentage, of the available appropriation is determined by a formula using the state's ''number of children,'' as adjusted for geographic variation in health costs and subject to certain floors and a ceiling.

Beginning with the FY2001 SCHIP allotment, the ''number of children'' is equal to (1) 50 percent of the number of children in the state who are low income (with ''low income'' defined as having family income below 200% of the federal poverty threshold), plus (2) 50 percent of the number of *uninsured* low-income children in the state. The source of data is the average of the number of such children, as reported and defined in the three most recent Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS) before the beginning of the calendar year in which the applicable fiscal year begins. For example, in determining the FY2007 allotments, the three most recent supplements available before January 1, 2006, were used. Thus, states' FY2007 allotments were based on the ''number of children'' using data that covered calendar years 2002, 2003 and 2004.

The adjustment for geographic variations in health costs is 85% of each state's variation from the national average in its average wages in the health services industry. The source of data is the average wages from mandatory reports filed quarterly by every employer on their unemployment insurance contributions and provided to the Department of Labor's Bureau of Labor Statistics (BLS). A three-year average of these data is also required in the statute.

Each state's ''number of children,'' as adjusted for geographic variation in health costs, is calculated as a percentage of the national total. This is the state's preliminary proportion of the available SCHIP appropriation, against which the floors and ceiling are compared.

Since the beginning of SCHIP, no state's share of the available appropriation could result in an allotment of less than $2 million. No state has ever been affected by this floor. Beginning with the FY2000 allotment, two additional floors also applied: (1) no state's share could be less than 90% of last year's share, and (2) no state's share could be less than 70% of its FY1999 share. (Each state's FY1999 share was identical to its FY1998 share, per P.L. 105–277.)

A ceiling has also applied beginning with the FY2000 allotment: No state's share can exceed 145% of its FY1999 share.

Once the floors and ceiling are applied to affected states to produce their adjusted proportion, the other states' shares are adjusted proportionally to use exactly 100% of the available appropriation. Each state's adjusted proportion multiplied by the appropriation available to states for a fiscal year results in each state's federal SCHIP allotment for that fiscal year.

Explanation of Provision

The annual CHIP funds available to states, including the District of Columbia—that is, the available national allotment—is the amount of the total appropriation remaining after amounts allotted to the territories.

For FY2008, a state's allotment is calculated as 110% of the greatest of the following four amounts: (1) the state's FY2007 federal CHIP spending multiplied by the annual adjustment; (2) the state's FY2007 federal CHIP allotment multiplied by the annual adjustment; (3) for states that were determined in FY2007 to have exhausted their own federal CHIP allotments (and therefore designated a shortfall state for FY2007), the state's FY2007 projected spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection) multiplied by the annual adjustment; and (4) the state's FY2008 federal CHIP projected spending as of August 2007 and certified by the state to the Secretary not later than September 30, 2007.

The annual adjustment for health care cost growth and child population growth is the product of (1) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the fiscal year over the prior fiscal year, and (2) 1.01 plus the percentage increase in the child population (under age 19) in each state as of July 1 of the fiscal year over the prior fiscal year's, based on the most timely and accurate published estimates from the Census Bureau.

For FY2009 to FY2012, a state's allotment is calculated as 110% of its projected spending for that year, as submitted to CMS no later than August 31 of the preceding fiscal year.

For FY2008, if the state allotments as calculated exceed the available national allotment, the allotments are reduced proportionally. For FY2009 to FY2012, if the state allotments as calculated exceed the available national allotment, then the available national allotment is distributed to each state according to its percentage calculated as the sum of the following four factors:

Each state's projected federal CHIP expenditures for that fiscal year (as certified by the state to the Secretary no later than the August 31 of the preceding fiscal year), calculated as a percentage of the national total, multiplied by 75%;

Each state's number of low-income children (based on the most timely and accurate published estimates from the Census Bureau), calculated as a percentage of the national total, multiplied by 12½%;

Each state's projected federal CHIP expenditures for the preceding fiscal year (as certified by the state to the Secretary in November of the fiscal year), calculated as a percentage of the national total, multiplied by 7½%; and

Each state's actual federal CHIP expenditures for the second preceding fiscal year, as determined by the Secretary, calculated as a percentage of the national total, multiplied by 5%.

If a state's projected CHIP expenditures for FY2009 to FY2012 are at least 10% more than the last year's allotment (excluding any reduction in states' allotments due to insufficient available national allotment) then, unless the state received approval in the prior year of a state plan amendment or waiver to expand CHIP coverage or the state received a payment from the CHIP Contingency Fund, the state must submit to the Secretary by August 31 before the fiscal year information relating to the factors that contributed to the need for the increase in the state's allotment, as well as any other information that the Secretary may require for the state to demonstrate the need for the increase in the state's allotment. The Secretary shall notify the state in writing within 60 days after receipt of the information that (1) the projected expenditures are approved or disapproved (and if disapproved, the reasons for disapproval); or (2) specified additional information is needed. If the Secretary disapproved the projected expenditures or determined additional information is needed, the Secretary shall provide the state with a reasonable opportunity to submit additional information to demonstrate the need for the increase in the State's allotment for the fiscal year. If a determination has not determined by September 30 whether the state has demonstrated the need for the increase in its allotment, the Secretary shall provide the state with a provisional allotment for the fiscal year equal to 110% of last year's allotment (excluding any reduction in states' allotments due to insufficient available national allotment). Once the Secretary makes a determination, the Secretary may adjust the state's allotment (and the allotments of other states) accordingly, but not later than November 30 of the fiscal year.

For FY2008 allotment factors based on CHIP expenditures, the Secretary of Health and Human Services (HHS) shall use the most recent FY2007 expenditure data available to the Secretary before the start of FY2008. The Secretary may adjust the FY2008 allotments based on the actual expenditure data reported to CMS no later than November 30, 2007; the Secretary may not make adjustments after December 31, 2007.

For purposes of determining a state's allotment, the state's projected expenditures shall include payments projected using §2105(g) (discussed in Section 110) and for certain CHIP-enrolled parents and childless adults (discussed in Section 105).

SECTION 103. ONE-TIME APPROPRIATION FOR FY2012

Current Law

No provision.

Explanation of Provision

In FY 2012, a one-time appropriation of $12,500,000,000 shall be made to the Secretary of Health and Human Services to add to the funds already provided under section 2104(a) for that year only. Such funds shall be distributed by the Secretary in a manner consistent with and under the same terms and conditions of section 102 of this Act.

SECTION 104. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID

Current Law

The territories were to receive 0.25 percent of the total appropriations provided in §2104(a). Later legislation added specific appropriations for the territories in FY1999 to FY2007:

$32,000,000 in FY 1999;
$34,200,000 in FY 2000;
$34,200,000 in FY 2001;
$25,200,000 in FY 2002;
$25,200,000 in FY 2003;
$25,200,000 in FY 2004;
$32,400,000 in FY 2005;
$32,400,000 in FY 2006; and
$40,000,000 in FY 2007.

For FY 1999, the $32 million represented approximately 0.75 percent of the total appropriations in §2104(a). For FY2000 to FY2007, the additional appropriation equaled 0.8 percent of the total appropriations in §2104(a). Combined with the 0.25 percent available through the original enacting legislation, the territories were allotted 1.05% of the total appropriations in §2104(a) from FY2000 to FY2007.

The amounts set aside for the territories were distributed according to the following percentages provided in statute: Puerto Rico, 91.6 percent; Guam, 3.5 percent; the Virgin Islands, 2.6 percent; American Samoa, 1.2 percent; and the Northern Mariana Islands, 1.1 percent.

Medicaid (and SCHIP) programs in the territories are subject to spending caps specified in statute. The federal Medicaid matching rate, which determines the share if Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps. For the 50 states and DC, certain administrative functions have a higher federal match. For example, startup expenses for specified computer systems are matched at 90%, and there is a 100% match for the implementation and operation of immigration status verification systems.

Explanation of Provision

From the national CHIP appropriation, the allotments to the territories are calculated as follows. For FY2008, each territory's allotment is its highest annual federal CHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth. FY2007 spending will be determined by the Secretary based on the most timely and accurate published estimates of the Census Bureau. For FY2009 through FY2012, each territory's allotment is the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth.

For FY2008 and each fiscal year thereafter, federal matching payments for specified data reporting systems (i.e., the design, development, and operations of claims processing systems and citizenship documentation data systems in each of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would be subject to the 90% federal match rate for the start-up expenses associated with such systems and the 75% federal match rate for the operation of such systems without regard to the specified spending caps.

The provision would require the Government Accountability Office (GAO) to submit a report to the appropriate committees of Congress not later than September 30, 2009, with regard to the territories' eligible Medicaid and CHIP populations, their historical and projected spending and the ability of capped funding streams to address such needs, the extent to which the federal poverty level is used for determining Medicaid and CHIP eligibility in the territories, and the extent to which the territories participate in data collection and reporting with regard to Medicaid and CHIP and specifically the extent to which they participate in the Current Population Survey versus the American Community Survey, which are federal surveys that estimate the number of low-income children in the states. The report is also to provide recommendations for improving Medicaid and CHIP funding to the territories.

SECTION 105. INCENTIVE BONUSES FOR STATES

Current Law

No provision.

Explanation of Provision

Incentive Pool

A CHIP Incentive Bonuses Pool is established in the U.S. Treasury. The Incentive Pool receives deposits from an initial appropriation in FY2008 of $3 billion, along with transfers from six different potential sources, with the currently available but not immediately required funds invested in interest-bearing U.S. securities that provide additional income into the Incentive Pool. The six sources for deposits are as follows:

On December 1, 2007, the amount by which states' FY2006 and FY2007 allotments not expended by September 30, 2007, exceed 50% of the federal share of the FY2008 allotment, as determined by the Secretary by not later than October 1, 2007;

On each December 1 from 2008 to 2012, any of the annual CHIP appropriation not used by the states;

On October 1 of fiscal years 2009 to 2012, the amount by which the unspent funds from the prior year's allotment exceeds the applicable percentage of that allotment. The applicable percentage is 20% for FY2009, and 10% for FY2010, FY2011, and FY2012;

Any original allotment amounts not expended by the end of their second year of availability;

On October 1, 2009, any amounts set aside for transition off of CHIP coverage for childless adults that are not expended by September 30, 2009; and

On October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap, as well as any Contingency Fund payments provided to a state that are unspent at the end of the fiscal year following the one in which the funds were provided.

Funds from the Incentive Pool are payable in FY2008 to FY2012 to states that have increased their Medicaid and CHIP enrollment among low-income children above a defined baseline, with associated payments as follows (reduced proportionally if necessary). (For purposes of Incentive Pool policies, a ''child'' enrolled in Medicaid means an individual under age 19—or age 20 or 21, if a state has so elected under its Medicaid plan; and ''low-income children'' means children in

families with incomes at 200% of federal poverty or below.) Beginning in FY2009, a state may receive a payment from the Incentive Pool if its average monthly enrollment of low-income children in CHIP and Medicaid for the coverage period (which is defined as the last two quarters of the preceding fiscal year and the first two quarters of the fiscal year, except that for FY2009 it is based only on the first two quarters of FY2009) exceeds the baseline monthly average.

For FY2009, the baseline monthly average is each state's average monthly enrollment in the first two quarters of FY2007 enrollment (as determined over a 6–month period on the basis of the most recent information reported through the Medicaid Statistical Information System (MSIS) multiplied by the sum of 1.02 and the percentage increase in the population of low-income children in the state from FY2007 to FY2009, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of FY2009. For FY2010 onward, the baseline monthly average is the prior year's baseline monthly average multiplied by the sum of 1.01 and the percentage increase in the population of low-income children in the state over the preceding fiscal year, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of the fiscal year.

A state eligible for a bonus shall receive in the last quarter of the fiscal year the following amount, depending on the ''excess'' of the state's enrollment above the baseline monthly average: (i) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX does not exceed 2 percent, the product of $75 and the number of such individuals included in such excess; (ii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 2 percent, but does not exceed 5 percent, the product of $300 and the number of such individuals included in such excess; and (iii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 5 percent, the product of $625 and the number of such individuals included in such excess. For FY2010 onward, these dollar amounts are to be increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year beginning on January 1 of the coverage period over that of the preceding coverage period.

Payments from the Incentive Pool shall be used for any purpose that the State determines is likely to reduce the percentage of low-income children in the State without health insurance.

Redistribution of FY2005 Allotments

An appropriation of $5,000,000 is provided to the Secretary for FY2008 for improving the timeliness of MSIS and to provide guidance to states with respect to any new reporting requirements related to such improvements. Amounts appropriated are available until expended. The resulting improvements are to be designed and implemented so that beginning no later than October 1, 2008, Medicaid and CHIP enrollment data are collected and analyzed by the Secretary within six months of submission.

FY2005 original CHIP allotments unspent at the end of FY2007 are to be redistributed on a proportional basis to states that were projected at any point in FY2007 to exhaust their federal CHIP allotments.

SECTION 106. PHASE-OUT OF COVERAGE FOR NON-PREGNANT CHILDLESS ADULTS UNDER CHIP, CONDITIONS FOR COVERAGE OF PARENTS

Current Law

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as ''waive-able.'' SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP. States may obtain waivers that allow them to provide services to individuals not traditionally eligible for SCHIP, or limit benefit packages for certain groups as long as the Secretary determines that these programs further the goals of SCHIP.

Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an ''allotment neutrality test'' where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels.

Under current law, including 1115 waiver authority, states cover pregnant women, parents of Medicaid and SCHIP eligible children and childless adults in their SCHIP programs.

The Deficit Reduction Act of 2005 prohibited the approval of new demonstration programs that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation and renewal of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved under the Section 1115 waiver authority before February 8, 2006.

Explanation of Provision

Childless Adults

The provision would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to nonpregnant childless adults (hereafter referred to as applicable existing waivers) on or after the date of enactment of this Act. Beginning on or after October 1, 2008, rules regarding the period to which an applicable existing waiver would apply, individuals eligible for coverage under such waivers, and the amount of federal payment available for such coverage would be subject to the following requirements: (1) no federal CHIP funds would be available for coverage of nonpregnant childless adults under an applicable existing waiver after September 30, 2008, (2) State-requested extensions of applicable existing waivers that would otherwise expire before October 1, 2008, would be granted by the Secretary but only through September 30, 2008, and (3) coverage to a nonpregnant childless adult under applicable existing waivers provided during FY2008 will be reimbursed at the CHIP enhanced FMAP rate.

States with applicable existing waivers (that are otherwise terminated under this provision) would be permitted to extend coverage, through FY2009, to individual nonpregnant childless adults who received coverage under the applicable existing waiver at any time during FY2008 (regardless of whether the individual lost coverage at any time during FY2008 and was later provided benefit coverage under the waiver in that fiscal year) subject to the following restrictions: (1) for each such State, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of the State's projected FY2008 expenditures (as certified by the state and submitted to the Secretary by August 31, 2008) for providing coverage under the waiver to such individuals in FY2008 increased by the annual adjustment for per capita health care growth (described in Section 102 of this bill), (2) the Secretary may adjust the set aside amount based on State-reported FY2008 expenditure data (reported on CMS Form 64 or CMS Form 21 not later than November 30, 2008), but in no case shall the Secretary adjust such amount after December 31, 2008, and (3) the Secretary would pay an amount equal to the federal Medicaid matching rate for expenditures related to such coverage (provided during FY2009) up to the set-aside spending cap.

States with existing CHIP waivers to extend coverage to nonpregnant childless adults (that are otherwise terminated under this provision) would be permitted to submit a request to CMS (not later than June 30, 2009) for a Medicaid nonpregnant childless adult waiver. For such states, the Secretary would be required to make a decision to deny or approve such application within 90 days of the date of submission. For such states, if no CMS decision to approve or deny such request has been made as of September 30, 2009, the provision would allow such application to be deemed approved.

States with applicable existing waivers that request a Medicaid nonpregnant childless adult waiver under this provision would be required to meet the following ''budget neutrality'' requirements. For fiscal year 2010, allowable waiver expenditures for such populations would not be permitted to exceed the total amount payments made to the State (as specified above) for FY2009, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for fiscal year 2010 over fiscal year 2009). In the case of any succeeding fiscal year, allowable waiver expenditures for such populations would not be permitted to exceed each such State's set aside amount (described above) for the preceding fiscal year, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for such fiscal year over the prior fiscal year.

Parents

The provision would also prohibit the approval of additional Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to parent(s) of a targeted low-income child(ren) (hereafter referred to as applicable existing CHIP parent coverage waiver) on or after the date of enactment of this Act. Beginning on or after October 1, 2009, rules regarding the period to which an applicable existing CHIP parent coverage waiver extends coverage to eligible populations, and the amount of federal payment available for coverage to such populations under the waiver would be subject to the following requirements: (1) State-requested extensions of applicable existing CHIP-financed Section 1115 parent coverage waivers that would otherwise expire before October 1, 2009, would be granted by the Secretary but only through September 30, 2009, and (2) the CHIP enhanced FMAP rate would apply for such coverage to such eligible populations during FY2008 and FY2009.

States with existing CHIP waivers to extend coverage to parent(s) of targeted low-income child(ren) would be permitted to continue such assistance during each of fiscal

years 2010, 2011, and 2012 subject to the following requirements: (1) for each such State and for each such fiscal year, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of 110% of the State's projected expenditures (as certified by the state and submitted to the Secretary by August 31 of the preceding fiscal year) for providing waiver coverage to such individuals enrolled in the waiver in the applicable fiscal year, and (2) the Secretary would pay the State from the set aside amount (specified above) for each such fiscal year an amount equal to the applicable percentage for expenditures in the quarter to provide coverage as specified under the waiver to parent(s) of targeted low-income child(ren).

In fiscal year 2010 only, costs associated with such parent coverage would be subject to each such state's CHIP enhanced FMAP for States that meet one of the outreach or coverage benchmarks (listed below) in FY2009, or each such state's Medicaid FMAP rate for all other states. The provision would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

For fiscal year 2011 or 2012, costs associated with such parent coverage would be subject to: (1) each such state's Reduced Enhanced Matching Assistance Percentage (REMAP) (i.e., a percentage which would be equal to the sum of (a) each such state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between each such state's FMAP rate and each such state's enhanced FMAP rate) if the state meets one of the coverage benchmarks (listed below) for FY2010 or FY2011 (as applicable), or (2) each such state's FMAP rate if the state failed to meet any of the coverage benchmarks (listed below) for the applicable fiscal year. The provision would prohibit federal matching payments for the payment of services beyond the setaside spending cap.

FY2010 outreach and coverage benchmarks include: (1) the state implemented a significant child outreach campaign including (a) the state was awarded an outreach and enrollment grant (under Section 201 of this bill) for fiscal year 2009, (b) the state implemented 1 or more process measures for that fiscal year, or (c) the state has submitted a specific plan for outreach for such fiscal year, (2) the state ranks in the lowest 1/3 of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, or (3) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

FY2011 and 2012 coverage benchmarks include: (1) the state ranks in the lowest ⅓ of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, and (2) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

A rule of construction clarifies that states are not prohibited from submitting applications for 1115 waivers to provide medical assistance to a parent of a targeted low-income child.

The General Accountability Office would be required to conduct a study to determine if the coverage of a parent, caretaker relative, or legal guardian of a targeted low-income child increases the enrollment of or quality of care for children, and if such parents, relatives, and legal guardians are more likely to enroll their children in CHIP or Medicaid. Results of the study (and report recommended changes) would be reported to appropriate committees of Congress 2 years after the date of enactment.

SECTION 107. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT

Current Law

Under SCHIP, states can cover pregnant women ages 19 and older in one of two ways: (1) via a special waiver of program rules (through Section 1115 authority), or (2) by providing coverage as permitted through regulation. In the latter case, coverage includes prenatal and delivery services only.

In general, SCHIP allows states to cover targeted low-income children with family income that is above applicable Medicaid eligibility levels in a given state. States can set the upper income level up to 200% FPL, or if the applicable Medicaid income level was at or above 200% FPL before SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. Other SCHIP eligibility restrictions include (1) the child must be uninsured, (2) the child must be otherwise ineligible for regular Medicaid, and (3) the child cannot be an inmate of a public institution or a patient in an institution for mental disease, or eligible for coverage under a state employee health plan. States may provide SCHIP coverage to children who are covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program. States may use enrollment restrictions such as capping total program enrollment, creating waiting lists, and instituting a minimum period of no insurance (e.g., 6 months) before being eligible.

Under regular Medicaid, states must provide coverage for pregnant women with income up to 133% FPL, and at state option, may extend such coverage to pregnant women with income up to 185% FPL. States must also provide coverage to first-time pregnant women with income that meets former cash assistance program rules (which were generally well below 100% FPL). The period of coverage for these mandatory and optional pregnant women is during pregnancy through the end of the month in which the 60 days postpartum period ends. In addition, waiver authority may be used to cover pregnant women at even higher income levels and for extended periods of time (e.g., 18 or 24 months postpartum).

Under regular Medicaid, states may temporarily enroll pregnant women whose family income appears to be below Medicaid income standards for up to 2 months until a final formal determination of eligibility is made. Entities that may qualify to make such presumptive eligibility determinations for pregnant women include Medicaid providers that are outpatient hospital departments, rural health clinics and certain other clinics, and other entities including certain primary care health centers and rural health care programs funded under Sections 330 and 330A of the Public Health Service Act, grantees under the Maternal and Child Health Block Grant Program, entities receiving funds under the Health Services for Urban Indians program, and entities that participate in WIC, the Commodity Supplemental Food Program, a state perinatal program (as designated by the state), or in the Indian Health Service or a health program or facility operated by tribes or tribal organizations under the Indian Self Determination Act.

Mandatory Medicaid eligibility applies to children under age 6 in families with income at or below 133% FPL. In addition, states may cover newborns under age 1 up to 185% FPL under Medicaid. Children born to Medicaid-eligible pregnant women must be deemed to be eligible for Medicaid from the date of birth up to age 1 so long as the child is a member of the mother's household, and the mother remains eligible for Medicaid (or would remain eligible if pregnant). During this period of deemed eligibility for the newborn, for claiming and payment purposes, the Medicaid identification (ID) number of the mother must also be used for the newborn, unless the state issues a separate ID number for the child during this period. In general, newborns may also be enrolled in SCHIP if they meet the applicable financial standards in a given state, which build on top of Medicaid's rules.

For families with income below 150% FPL, premiums cannot exceed nominal amounts specified in Medicaid regulations, and service-related cost-sharing is limited to nominal Medicaid amounts for the subgroup under 100% FPL and slightly higher amounts in SCHIP regulations for the subgroup with income between 100–150% FPL.

For families with income above 150% FPL, premiums and cost-sharing may be imposed in any amount as long as such costs for higher-income children are not less than the costs for lower-income children. Total premiums and cost-sharing incurred by all SCHIP children cannot exceed 5% of annual family income.

Other cost-sharing protections also apply. Applicable premium and cost-sharing amounts cannot favor children from families with higher income over children in families with lower income. No cost-sharing may be applied to preventive services.

Explanation of Provision

The provision would allow states to provide optional coverage under CHIP to pregnant women, through a state plan amendment, if certain conditions are met, including (1) the state has established an income eligibility level of at least 185% FPL for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid, (2) the state does not apply an effective income level under the state plan amendment for pregnant women that is lower than the effective income level (expressed as a percent of poverty and accounting for applicable income disregards) for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid on the date of enactment of this provision to be eligible for Medicaid as pregnant women, (3) the state does not provide coverage for pregnant women with higher family income without covering such pregnant women with a lower family income, (4) the state provides pregnancy-related assistance (defined below) for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the state provides child health assistance for targeted low-income children under the state CHIP plan, and in addition to providing child health assistance for such women, (5) the state does not apply any exclusion of benefits for pregnancy-related assistance based on any pre-existing condition or any waiting period (including waiting periods to ensure that CHIP does not substitute for private insurance coverage), and (6) the state must provide the same cost-sharing protections to pregnant women as applied to CHIP children, and all cost-sharing incurred by targeted low-income pregnant women under CHIP would be capped at 5% of annual family income.

States that elect this new optional coverage for pregnant women under CHIP and that meet all the above conditions associated with this option, may also elect to provide presumptive eligibility for pregnant women, as defined in the Medicaid statute, to targeted low-income pregnant women under CHIP.

Pregnancy-related assistance would include all the services covered as child health assistance under the state's CHIP program, and includes medical assistance that would be provided to a pregnant woman under Medicaid, during pregnancy through the end of the month in which the 60 day postpartum period ends. The upper income limit for coverage of targeted low-income pregnant women under CHIP could be up to the level for coverage of targeted low-income children in the state. As with targeted low-income children under CHIP, the new group of targeted low-income pregnant women must be determined eligible, be uninsured, and must not be an inmate of a public institution or a patient in an institution for mental disease or eligible for coverage under a state employee health benefit plan. Also as with targeted low-income children, pregnant women may include those covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program.

The provision would also deem children born to the new group of targeted low-income pregnant women under CHIP to be eligible for Medicaid or CHIP, as applicable.

Such newborns would be covered from birth to age 1. During this period of eligibility, the mother's identification number must also be used for filing claims for the newborn, unless the state issues a separate identification number for that newborn.

The provision would also address States that provide assistance through other options. The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide (A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations, or (B) pregnancy-related services through the application of any other waiver authority (as in effect on June 1, 2007).

Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

A rule of construction clarifies that nothing in this subsection shall be construed to (A) infer the congressional intent regarding the legality or illegality of the content of sections of title 42, Code of Federal Regulations, specified in paragraph (1)(A), or (B) modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).

For the new group of targeted low-income pregnant women, additional conforming amendments would prohibit cost-sharing for pregnancy-related services and waiting periods prior to enrollment or for the purpose of preventing crowd-out of private health insurance.

SECTION 108. CHIP CONTINGENCY FUND

Current Law

No provision.

Explanation of Provision

A CHIP Contingency Fund is established in the U.S. Treasury. The Contingency Fund receives deposits through a separate appropriation. For FY2009, the appropriation to the Fund is equal to 12.5% of the available national allotment for CHIP. For FY2010 through FY2012, the appropriation is such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 12.5% of that fiscal year's available national allotment for CHIP. Balances that are not immediately required for payments from the Fund are to be invested in U.S. securities that provide addition income to the Fund, as long as the annual payments do not cause the Fund to exceed 12.5% of the available national allotment for CHIP. Amounts in excess of the 12.5% limit shall be deposited into the Incentive Pool. For purposes of the CHIP Contingency Fund, amounts set aside for block grant payments for transitional coverage of childless adults shall not count as part of the available national allotment.

Payments from the Fund are to be used only to eliminate any eligible state's shortfall (that is, the amount by which a state's available federal CHIP allotments are not adequate to cover the state's federal CHIP expenditures, on the basis of the most recent data available to the Secretary or requested from the state by the Secretary).

The Secretary shall separately compute the shortfalls attributable to children and pregnant women, to childless adults, and to parents of low-income children. No payment from the Contingency Fund shall be made for nonpregnant childless adults. Any payments for shortfalls attributable to parents shall be made from the Fund at the relevant matching rate. Contingency funds are not transferable among allotments.

Eligible states, which cannot be a territory, for a month in FY2009 to FY2012 are those that meet any of the following criteria:

The state's available federal CHIP allotments are at least 95% but less than 100% of its projected federal CHIP expenditures for the fiscal year (i.e., less than 5% shortfall in federal funds), without regard to any payments provided from the Incentive Fund; or

The state's available federal CHIP allotments are less than 95% of its projected federal CHIP expenditures for the fiscal year (i.e., more than 5% shortfall in federal funds) and that such shortfall is attributable to one or more of the following: (1) One or more parishes or counties has been declared a major disaster and the President has determined individual and public assistance has been warranted from the federal government pursuant to the Stafford Act, or a public health emergency was declared by the Secretary pursuant to the Public Health Service Act; (2) the state unemployment rate is at least 5.5% during any 13 consecutive week period during the fiscal year and such rate is at least 120% of the state unemployment rate for the same period as averaged over the last three fiscal years; (3) the state experienced a recent event that resulted in an increase in the percentage of low-income children in the state without health insurance (as determined on the basis of the most timely and accurate published estimates from the Census Bureau) that was outside the control of the state and warrants granting the state access to the Fund, as determined by the Secretary.

The Secretary shall make monthly payments from the Fund to all states determined eligible for a month. If the sum of the payments from the Fund exceeds the amount available, the Secretary shall reduce each payment proportionally.

If a state was determined to be eligible in a given fiscal year, that does not make the state eligible in the following fiscal year. In the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children as described above, any related Contingency Fund payment shall remain available until the end of the following fiscal year.

The Secretary shall provide annual reports to Congress on the Contingency Fund, the payments from it, and the events that caused states to apply for payment.

SECTION 109. 2-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS

Current Law

SCHIP allotments (currently through FY2007) are available for three years. Allotments unspent after three years are available for reallocation. For example, the FY2004 allotment was available through the end of FY2006; any remaining balances at the end of FY2006 were redistributed to other states.

Explanation of Provision

CHIP allotments through FY2006 are available for three years. CHIP allotments made for FY2007 through FY2012 are available for two years.

Payments to states from the Incentive Pool are available until expended by the state. Payments for a month from the Contingency Fund are available through the end of the fiscal year, except in the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children.

States' federal CHIP expenditures on or after October 1, 2007, shall be counted first against the Contingency Funds from the earliest available month in the earliest fiscal year, then against the earliest available allotments.

A State may elect, but is not required, to count CHIP expenditures against any incentive bonuses paid to the State.

Expenditures for coverage of nonpregnant childless adults in FY2009 and of parents of targeted low-income children in FY2010 through FY2012 shall be counted only against the amount set aside for such coverage

SECTION 110. LIMITATION ON MATCHING RATE FOR STATES THAT PROPOSE TO COVER CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. There are statutory exceptions to the FMAP formula for the District of Columbia (since FY1998) and Alaska (for FY1998–FY2007). In addition, the territories have FMAPs set at 50% and are subject to federal spending caps.

The enhanced FMAP (E–FMAP) for SCHIP equals a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. For example, in states with an FMAP of 60%, the E–FMAP equals the FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%). The E–FMAP has a statutory minimum of 65% and maximum of 85%.

Explanation of Provision

For child health assistance or health benefits coverage furnished in any fiscal year inning with FY2008 to a targeted low-income child whose effective family income would exceed 300% of the federal poverty line but for the application of a general exclusion of

a block of income that is not determined by type of expense or type of income, states would be reimbursed using the FMAP instead of the E-FMAP for services provided to that child. An exception would be provided for states that, on the date of enactment of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007 has an approved State plan amendment or waiver or has enacted a State law to submit a State plan amendment to provide child health assistance or health benefits under their state child health plan or its waiver of such plan to children above 300% of the poverty line.

SECTION 111. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE CHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN CURRENT LAW

Current Law

Section 2105(g) of the Social Security Act permits qualifying states to apply federal SCHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not SCHIP-funded expansions of Medicaid). Specifically, these federal SCHIP funds are used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP) and the Medicaid FMAP that the state is already receiving for these children. Funds under this provision may only be claimed for expenditures occurring after August 15, 2003.

Qualifying states are limited in the amount they can claim for this purpose to the lesser of the following two amounts: (1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998, FY1999, FY2000, FY2001, FY2004, FY2005, FY2006, and FY2007 (hence the ''terms ''20% allowance'' and ''20% spending''); and (2) the state's available balances of those allotments. If there is no balance, states may not claim Section 2105(g) spending.

The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of the federal poverty level or higher prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

SCHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an SCHIP-funded expansion of Medicaid) who are under age 19 and whose family income exceeds 150% of poverty, to pay the difference between the SCHIP enhanced FMAP and the regular Medicaid FMAP.

Explanation of Provision

Qualifying states under §2105(g) may also use available balances from their CHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the CHIP enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

TITLE II—A OUTREACH AND ENROLLMENT

SECTION 201. GRANTS FOR OUTREACH AND ENROLLMENT

Current Law

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the non-federal share, using state tax revenues, for example, but can also use local government funds to comprise a portion of the non-federal share. Generally, the non-federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, which meets certain requirements. Apart from these benefit payments; SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Explanation of Provision

The provision would establish a new grant program under CHIP to finance outreach and enrollment efforts that increase participation of eligible children in both Medicaid and CHIP. For the purpose of awarding grants, the provision would appropriate $100 million for fiscal years 2008 through 2012. These amounts would be in addition to amounts appropriated for CHIP allotments to states (as per Section 2104 of the CHIP statute) and would not be subject to restrictions on expenditures for outreach activities under current law.

For each fiscal year, the provision would require that ten percent of the funds appropriated for this new grant would be set aside to finance a national enrollment campaign (described below), and an additional 10 percent would be set-side to be used by the Secretary to award grants to Indian Health Service providers and Urban Indian Organizations that receive funds under title V of the Indian Health Care Improvement Act for outreach to, and enrollment of, children who are Indians.

The provision would require the Secretary to develop and implement a national enrollment campaign to improve the enrollment of under-served child populations in Medicaid and CHIP. Such a campaign may include: (1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the programs each Secretary administers that often serve the same children, (2) the integration of information about Medicaid and CHIP in public health awareness campaigns administered by the Secretary, (3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all states participate in such hotlines, (4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy, (5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency, and (6) such other outreach initiatives as the Secretary determines would increase public awareness of Medicaid and CHIP.

In awarding grants, the Secretary would be required to give priority to entities that propose to target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations, including proposals that address cultural and linguistic barriers to enrollment, and which submit the most demonstrable evidence that (1) the entity includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (2) the entity has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving coverage under CHIP or Medicaid.

To receive grant funds, eligible entities would be required to submit an application to the Secretary in such form and manner, and containing such information as the Secretary chooses. As noted above, such applications must include evidence that the entity (a) includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (b) has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving CHIP or Medicaid benefits. The applicable must also include specific quality or outcome performance measures to evaluate the effectiveness of activities funded by the grant. In addition, the applicable must contain an assurance that the entity will (1) conduct an assessment of the effectiveness of such activities against the performance measures, (2) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessment, and (3) in the case of an entity that is not a state, provide the state with enrollment data and other information necessary for the state to make projections of eligible children and pregnant women. The Secretary would be required to make publicly available the enrollment data and information collected and reported by grantees, and would also be required to submit an annual report to Congress on the funded outreach and enrollment activities conducted under the new grant.

Seven types of entities would be eligible to receive grants, including (1) a state with an approved CHIP plan, (2) a local government, (3) an Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, or an Indian Health Service provider, (4) a federal health safety net organization, (5) a national, local, or community-based public or nonprofit organization, including organizations that use community health workers or community-based doula programs, (6) a faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with requirements of section 1955 of the Public Health Service Act relating to a grant award to non-governmental entities, or (7) an elementary or secondary school.

Federal health safety net organizations include a number of different types of entities, including for example: (1) federally qualified health centers, (2) hospitals that receive disproportionate share hospital (DSH) payments, (3) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects, certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (4) any other entity or consortium that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The provision defines ''community health worker'' as an individual who promotes health or nutrition within the community in which the individual resides by (1) serving as a liaison between communities and health

care agencies, (2) providing guidance and social assistance to residents, (3) enhancing residents' ability to effectively communicate with health care providers, (4) providing culturally and linguistically appropriate health or nutrition education, (5) advocating for individual and community health or nutrition needs, and (6) providing referral and follow-up services.

In the case of a State that is awarded an Outreach and Enrollment grant, the State would be required to meet a maintenance of effort requirement with regard to the state share of funds spent on outreach and enrollment activities under the CHIP state plan. For such states, the funds spent on outreach and enrollment under the state plan for a fiscal year would not permitted to be less than the State share of funds spent in the fiscal year preceding the first fiscal year for which the grant is awarded.

The provision would add translation and interpretation services to the specific health care activities that can be reimbursed under CHIP. Translation or interpretation services in connection with the enrollment and use of services under CHIP by individuals for whom English is not their primary language (as found by the Secretary for the proper and efficient administration of the state plan) would be matched at either 75% or the sum of the enhanced FMAP for the state plus five percentage points, whichever is higher.

In addition, the 10% limit on payments for other specific health care activities in current CHIP statute would not apply to expenditures for outreach and enrollment activities funded under this section.

SECTION 202. INCREASED OUTREACH AND ENROLLMENT OF INDIANS

(a) Agreements with States for Medicaid and CHIP Outreach on or Near Reservations to Increase the Enrollment of Indians in Those Programs

Current Law

No provision in the Social Security Act.

Section 404(a) of the IHCIA requires the Secretary to make grants or enter into contracts with Tribal Organizations for establishing and administering programs on or near federal Indian reservations and trust areas and in or near Alaska Native villages. The purpose of the programs is to assist individual Indians to enroll in Medicare, apply for Medicaid and pay monthly premiums for coverage due to financial need of such individuals. Section 404(b) of the IHCIA directs the Secretary, through the IHS, to set conditions for any grant or contract. The conditions include, but are not limited to: (1) determining the Indian population that is, or could be, served by Medicare and Medicaid; (2) assisting individual Indians to become familiar with and use benefits; (3) providing transportation to Indians to the appropriate offices to enroll or apply for medical assistance; and (4) developing and implementing both an income schedule to determine premium payment levels for coverage of needy individuals and methods to improve Indian participation in Medicare and Medicaid. Section 404(c) of the IHCIA authorizes the Secretary, acting through the IHS, to enter into agreements with tribes, Tribal Organizations, and Urban Indian Organizations to receive and process applications for medical assistance under Medicaid and benefits under Medicare at facilities administered by the IHS, or by a tribe, Tribal Organization or Urban Indian Organization under the Indian Self-Determination Act.

Explanation of Provision

The provision would amend Section 1139 of the Social Security Act (replacing the current Section 1139 provision dealing with an expired National Commission on Children).

The provision would encourage states to take steps to provide for enrollment of Indians residing on or near a reservation in Medicaid and CHIP. The steps could include outreach efforts such as: outstationing of eligibility workers; entering into agreements with the IHS, Indian Tribes (ITs), Tribal Organizations (TOs), and Urban Indian Organizations (UIOs) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The provision would not affect the arrangements between states and Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct administrative activities under Medicaid and CHIP.

The provision would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between states, and the IHS, ITs, TOs, or UIOs relating to the provision of benefits to Indians under Medicaid and CHIP.

The provision would specify that the following terms have the meanings given to these terms in Section 4 of the Indian Health Care Improvement Act: Indian, Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization.

(b) Nonapplication of 10 Percent Limit On Outreach and Certain Other Expenditures

Current Law

Title XXI of the Social Security Act provides states with annual federal SCHIP allotments based on a formula set in law. State SCHIP payments are matched by the federal government at an enhanced rate that builds on the base rate applicable to Medicaid. The SCHIP statute also specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Explanation of Provision

The provision would exclude from the 10% cap on CHIP payments for the four other specific health care activities described above: (1) expenditures for outreach activities to families of Indian children likely to be eligible for CHIP or Medicaid, or under related waivers, and (2) related informing and enrollment assistance activities for Indian children under such programs, expansions, or waivers, including such activities conducted under grants, contracts, or agreements entered into under Section 1139 of this Act.

SECTION 203. OPTION FOR STATES TO RELY ON FINDINGS BY AN EXPRESS LANE AGENCY TO DETERMINE COMPONENTS OF A CHILD'S ELIGIBILITY FOR MEDICAID OR CHIP

Current Law

Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. Generally, the Medicaid agency must determine the eligibility of each applicant no more than 90 days from the date of application for disability-based applications and 45 days for all other applications. The agency must assure that eligibility for care and services under the plan is determined in a manner consistent with the best interests of the recipients.

In limited circumstances outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used the state TANF agency may make the Medicaid eligibility determination, or the Secretary may enter into an agreement with a given state to allow the Social Security Administration (SSA) to determine Medicaid eligibility of aged, blind, or disabled individuals in that state.

Applicants must attest to the accuracy of the information submitted on their Medicaid applications, and sign application forms under penalty of perjury. Each state must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate state agency, qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service, and the state must verify the SSN with the Social Security Administration). States must also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations. State Medicaid overpayments made on behalf of individuals due to an error in determining eligibility may not exceed 3% of the State's total Medicaid expenditures in a given fiscal year. Erroneous excess payments that exceed the 3% error rate will not be matched with Federal Medicaid funds.

With regard to criteria for State Personnel Administration and Offices, current law requires each state plan to establish and maintain methods of personnel administration in accordance with the Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. States must assure compliance with the standards by local jurisdictions; assure that the U.S. Civil Service Commission has reviewed and determined the adequacy of state laws, regulations, and policies; obtain statements of acceptance of the standards by local agencies; submit materials to show compliance with these standards when requested by HHS; and have in effect an affirmative action plan, which includes specific action steps and timetables, to assure equal employment opportunity.

SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. Federal law requires that eligibility for Medicaid and SCHIP be coordinated when states implement separate SCHIP programs. In these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility.

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards for up

to 2 months until a final formal determination of eligibility is made. Entities qualified to make presumptive eligibility determinations for children include Medicaid providers, agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC). BIPA 2000 added several entities to the list of those qualified to make Medicaid presumptive eligibility determinations. These include agencies that determine eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; certain organizations providing food and shelter to the homeless; entities involved in enrollment under Medicaid, TANF, SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of HHS. These Medicaid presumptive eligibility rules for children also apply to SCHIP.

Explanation of Provision

The provision would create a three year demonstration program that would allow up to 10 states to use Express Lane at Medicaid and SCHIP enrollment and renewal. The demonstration would provide $44 million for systems upgrades and implementation (not coverage costs) and $5 million for an independent evaluation of the demonstration at the end of three years and a report on the demonstration's effectiveness to Congress. The report would be due one year after completion of the demonstration.

The Demonstration would allow states the option to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child under age 19 (or at state option age 20, or 21) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid (including the waiver of requirements of this title).

If a finding from an Express Lane agency results in a child not being found eligible for Medicaid or CHIP, the State would be required to determine Medicaid or CHIP eligibility using its regular procedures. The provision does not relieve states of their obligation to determine eligibility for medical assistance under Medicaid, or prohibit state options intended to increase enrollment of eligible children under Medicaid or CHIP. In addition, the provision requires states to inform the families (especially those whose children are enrolled in CHIP) that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated for an eligibility determination by the State Medicaid agency, and at the family's option they can seek a regular Medicaid eligibility determination.

The provision would allow States to rely on an Express Lane Agency finding that a child is a qualified alien as long as the Agency complies with guidance and regulatory procedures issued by the Secretary of Homeland Security for eligibility determinations of qualified aliens, and verifications of immigration status (that meet the requirements of Section 301 of this bill).

States that opt to use an Express Lane Agency to determine eligibility for Medicaid or CHIP may meet the CHIP screen and enroll requirements by using any of the following requirements: (1) establishing a threshold percentage of the Federal poverty level that is 30 percentage points (or such other higher number of percentage points) as the state determines reflects the income methodologies of the program administered by the Express Lane Agency and the Medicaid State plan, (2) providing that the child satisfies all income requirements for Medicaid eligibility, or (3) providing that such child has a family income that exceeds the Medicaid income eligibility threshold that serves as the lower income eligibility threshold for CHIP.

The provision would allow states to provide for presumptive eligibility under CHIP for a child who, based on an eligibility determination of an income finding from an Express Lane agency, would qualify for child health assistance under CHIP. During the period of presumptive eligibility, the State may determine the child's eligibility for CHIP based on telephone contact with family members, access to data available in electronic or paper format, or other means that minimize to the maximum extent feasible the burden on the family.

A State may initiate a Medicaid eligibility determination (and determine program eligibility) without a program application based on data obtained from sources other than the child (or the child's family), but such child can only be automatically enrolled in Medicaid (or CHIP) if the family affirmatively consented to being enrolled through affirmation and signature on an Express Lane agency application. The provision requires the State to have procedures in place to inform the individual of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations created by the enrollment (if applicable), and the actions the individual must take to maintain enrollment and renew coverage. For children who consent to enrollment in the State plan, the provision would allow the State to waive signature requirements on behalf of such child.

States that participate in the Express Lane Eligibility Demonstration would not be required to direct a child (or a child's family) to submit information or documentation previously submitted by the child or family to an Express Lane agency that the State relies on for its Medicaid eligibility determination. A participating state may rely on information from an Express Lane agency when evaluating a child's eligibility for Medicaid or SCHIP without a separate, independent confirmation of the information at the time of enrollment.

An Express Lane agency must be a public agency determined by the State agency to be capable of making the determinations described in the provisions of this section and is identified in the state plan under this title or Title XXI. Express Lane Agencies would include: (1) a public agency that determines eligibility for assistance under a State program funded under part A of title IV, a program funded under Part D of title IV, a State child health plan under title XXI, the Food Stamp Act of 1977, the Head Start Act, the Richard B. Russell National School Lunch Act, the Child Nutrition Act of 1966, or the Child Care and Development Block Grant, the Steward B. McKinney Homeless Assistance Act, the United States Housing Act of 1937, the Native American Housing Assistance and Self-Determination Act of 1996, (2) a state specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings, and (3) a public agency that is subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes.

Programs run through Title XX (SSBG) are not eligible Express Lane agencies. Private for-profit organizations are not eligible Express Lane agencies. Current law applies regarding the ability of Medicaid to contract with non-profit and for-profit agencies to administer the Medicaid application process with clarifying language that nothing in this demonstration exempts states from the merit-based system for Medicaid employees. A rule of construction would also clarify that states may not use the Express Lane option as a means of avoiding current merit-based employment requirements for Medicaid determinations.

In addition, the provision would require such agencies to notify the child's family (1) of the information that will be disclosed under this provision, (2) that the information will be used solely for the purposes of determining eligibility under Medicaid and CHIP, (3) that the family may elect not to have the information disclosed for such purposes. The Express Lane agency must also enter into or be subject to an interagency agreement to limit the disclosure and use of such information.

As part of the demonstration, signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from a source other than an applicant. The provision would provide that any signature requirement for a Medicaid application may be satisfied through an electronic signature.

States participating in the Demonstration will have to code which children are enrolled in Medicaid or CHIP by way of Express Lane for the duration of the demonstration. States must take a statistically valid sample, approved by CMS, of the children enrolled via Express Lane annually for full Medicaid eligibility review to determine eligibility error rate. States submit the error rate to CMS and if the error rate exceeds 3% either of the first two years, the state must show CMS what corrective actions are in place to improve upon their error rate and will be required to reimburse erroneous excess payments that exceed the allowable error rate of 3%. However, CMS does not have the authority to apply the error rate derived from the Express Lane sample to the entire Express Lane or Medicaid child population, or to take other punitive action against a state based on the error rate. States that participate in the Express Lane demonstration will continue to be subject to existing requirements under Medicaid requiring states to reimburse erroneous excess payments that exceed the allowable error rate of 3% consistent with 1903(u).

SECTION 204. AUTHORIZATION OF CERTAIN INFORMATION DISCLOSURE TO SIMPLIFY HEALTH COVERAGE DETERMINATIONS

Current Law

Each state must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate state agency, qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service, and the state must verify the SSN with the Social

Security Administration). States must also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations.

Explanation of Provision

The provision would authorize federal or State agencies or private entities with potential data sources relevant for the determination of eligibility under Medicaid (e.g., eligibility files, vital records about births, etc.) to share such information with the Medicaid agency if: (1) the child (or such child's parent, guardian, or caretaker relative) has provided advanced consent to disclosure, and has not objected to disclosure, (2) such data are used solely for the purpose of identifying, enrolling, and verifying potential eligibility for Medicaid medical assistance, and (3) an interagency agreement prevents the unauthorized use, disclosure, or modification of such data, and otherwise meets federal standards for safeguarding privacy and data security, and requires the State agency to use such data for the purposes of child enrollment in Medicaid. The provision would impose criminal penalties for persons who engage in unauthorized activities with such data.

For purposes of the Express Lane Demonstration only, the provision would also authorize the Medicaid and CHIP programs to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under such program from (1) the National New Hires Database, (2) the National Income Data collected by the Commissioner of Social Security, or (3) data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, CHIP and certain other programs.

Title III—Removal of Barriers to Enrollment

SECTION 301. VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID AND CHIP

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien. Nonqualified aliens can only receive limited emergency Medicaid benefits. Noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a ''satisfactory immigration status.''

Due to recent changes in federal law, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109–171) and modified by the Tax Relief and Health Care Act of 2006 (P.L. 109–432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence.

The citizenship documentation requirement is outlined under Section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement, including people who receive Medicare benefits, Social Security benefits on the basis of a disability, Supplemental Security Income benefits, child welfare assistance under Title IV–B of the Social Security Act, or adoption or foster care assistance under Title IV–E of the Social Security Act. An interim final rule on the requirement was issued in July 2006, and a final rule was issued in July 2007.

The citizenship documentation requirement does not apply to SCHIP. However, some states use the same enrollment procedures for all Medicaid and SCHIP applicants. As a result, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

Explanation of Provision

As part of its Medicaid state plan and with respect to individuals declaring to be U.S. citizens or nationals for purposes of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship documentation rules under Section 1903(x) or new rules under Section 1902(dd). The Secretary would not be allowed to waive this requirement.

Under a new Section 1902(dd), a state could meet its Medicaid state plan requirement for citizenship documentation by: (1) submitting the name and Social Security number (SSN) of an individual to the Commissioner of Social Security as part of a plan established under specified rules and (2) in the case of an individual whose name or SSN is invalid, providing the individual with an opportunity to cure the invalid determination with the Social Security Administration, followed by 90 days to present evidence of citizenship as defined in Section 1903(x) and disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided.

A state opting for name and SSN validation would be required to establish a program under which it submits each month to the Commissioner of Social Security for verification of the name and SSN of each individual enrolled in Medicaid that month who has attained the age of 1 before the date of the enrollment. In establishing its program, a state could enter into an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid.

At such times and in such form as the Secretary may specify, states would be required to provide information on the percentage of invalid names and SSNs submitted each month. If the average monthly percentage for any fiscal year is greater than 7%, the state shall develop and adopt a corrective plan and pay the Secretary an amount equal to total Medicaid payments for the fiscal year for individuals who provided invalid information multiplied by the ratio of the number of individuals with invalid information in excess of the 7% limited divided by the total number of individuals with invalid information. The Secretary could waive, in certain limited cases, all or part of such payment if a state is unable to reach the allowable error rate despite a good faith effort by the state. This provision shall not apply to a State for a fiscal year, if there is an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid, as of the close of the fiscal year.

States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.

The provision would also clarify requirements under the existing Section 1903(x). It would add ''a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe'' to the list of documents that provide satisfactory documentary evidence of citizenship or nationality, except for tribes located within states having an international border whose membership includes noncitizens, who would only be allowed to use such documents until the Secretary of HHS issues regulations authorizing the presentation of other evidence. It would require states to provide citizens with the same reasonable opportunity to present evidence that is provided under Section 1137(d)(4)(A) to noncitizens who must present evidence of satisfactory immigration status. Groups that are exempt from the Section 1903(x) citizenship documentation requirement would remain the same as under current law, except for the inclusion of a permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a mother on Medicaid. The provision would clarify that deemed eligibility applies to children born to noncitizen women on emergency Medicaid, and would require separate identification numbers for children born to these women.

In order to receive reimbursement for an individual who has, or is, declared to be a U.S. citizen or national for purposes of establishing CHIP eligibility, a state would be required to meet the Medicaid state plan requirement for citizenship documentation described above. The 90% and 75% reimbursement for name and SSN validation would be available under SCHIP, and would not count towards a state's CHIP administrative expenditures cap.

Except for technical amendments made by the provision and the application of citizenship documentation to CHIP, which would be effective upon enactment, the provision would be effective as if included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

SECTION 302. REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT

Current Law

During the implementation of SCHIP states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. As a result, substantial progress was made at the state level to simplify the application and enrollment processes to find, enroll, and maintain eligibility among those eligible for the program.

Explanation of Provision

The provision would require the State plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment. States would be deemed to comply with the above-listed requirement if (1) the State's application and renewal forms, and information verification processes are the same under Medicaid and CHIP for establishing and renewing eligibility for children and pregnant women, and (2) the state does not require a face-to-face interview during the application process.

Title IV—Elmination of Barriers to Providing Premium Assistance

Subtitle A—Additional State Option for Providing Premium Assistance

SECTION 401. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE

Current Law

Under Medicaid, a provision in the Omnibus Budget Reconciliation Act (OBRA) of 1990 created the health insurance premium payment (HIPP) program. The original HIPP provision required state Medicaid programs to pay a Medicaid beneficiary's share of costs

for group (employer-based) health coverage for any Medicaid enrollee for whom employer-based coverage is available when that coverage is both comprehensive and cost effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. Under the original provision, states were also required to purchase employer-based health insurance for non-Medicaid eligible family members if such family coverage was necessary for Medicaid-eligible individual to receive coverage, and as long as it was still cost-effective. States were also to provide coverage for those Medicaid covered services that are not included in the private plans. In August 1997, as part of the Balanced Budget Act, Congress amended the mandatory nature of the HIPP provision. Today, states can opt to use Medicaid funds to pay for premiums and other cost-sharing for Medicaid beneficiaries when coverage is available, comprehensive, and cost-effective.

Under SCHIP, the Secretary has the authority to approve funding for the purchase of ''family coverage'' if it is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans that would otherwise be provided to the children. While the term ''family coverage'' is not specifically defined in the statute, it has been interpreted to refer to either coverage for the entire family under an SCHIP program or under an employer-sponsored health insurance plan. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met.

Because of these requirements, implementation of premium assistance programs under Medicaid and SCHIP are not widespread. States cited difficulty in identifying potential enrollees, determining whether the subsidy would be cost-effective, and obtaining necessary information (e.g., information about the availability of employer-sponsored plans, covered benefits, available contributions, and the remaining costs) as some of the barriers to the implementation of such programs.

In August 2001, the Bush Administration introduced the Health Insurance Flexibility and Accountability (HIFA) Initiative under the Section 1115 waiver authority. Under HIFA, states were to direct unspent SCHIP funds to extend coverage to uninsured populations with annual income less than 200% FPL and to use Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). This resulted in an increased emphasis on states' use of the Section 1115 waiver authority to offer premium assistance for employer-based health coverage in lieu of full Medicaid and/or SCHIP coverage. ESI programs approved under the Section 1115 waiver authority are not subject to the same current law constraints required under Medicaid's HIPP program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost-effectiveness tests).

Explanation of Provision

The provision would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage. Qualified employer sponsored coverage would be defined as a group health plan or health insurance coverage offered through an employer that (1) qualifies as credible health coverage as a group health plan under the Public Health Service Act, (2) for which the employer contributes at least 40 percent toward the cost of the premium, and (3) is non-discriminatory in a manner similar to section 105(h) of the Internal Revenue Code but would not allow employers to exclude workers who had less than 3 years of service. Qualified employer-sponsored insurance would not include (1) benefits provided under a health flexible spending arrangement, (2) a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986.

The provision would establish a new cost effectiveness test for ESI programs. A group health plan or health insurance coverage offered through an employer would be considered qualified employer sponsored coverage if the state establishes that (1) the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in CHIP, or (2) the State establishes that the aggregate amount of State expenditures for the purchase of all such coverage for targeted low-income children under CHIP (including administrative expenses) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the CHIP state plan for all such children.

Premium assistance subsidies would be considered child health assistance for the purpose of making federal matching payments under the CHIP program, and the state would be considered a secondary payor for any items or services provided under ESI coverage. The provision defines premium assistance subsidies as an amount equal to the difference between the employee contribution for the employee only, and the employee contribution for the employee and CHIP-eligible child, less applicable premium cost sharing imposed under title XXI (including the employee contribution toward the 5 percent total annual aggregate cost-sharing limit under CHIP). States would be permitted to provide a premium assistance subsidy as reimbursement for out-of-pocket expenses directly to an employee, or directly to the employer. At the employer's option, the provision permits the employer to notify the State that it elects to opt out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such notification, the employer would be required to withhold the total amount of the employee contribution required for enrollment of the employee (and the child) in the ESI coverage and then the State would then pay the premium subsidy directly to the employee.

States would be required to provide supplemental coverage for each targeted low income child enrolled in the ESI plan consisting of items or services that are not covered, or are only partially covered, and cost-sharing protections consistent with the requirements of CHIP. States would be permitted to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified ESI coverage and collect all (or any) portion for cost-sharing imposed on the family.

Waiting periods (to prevent crowd-out of private coverage with public coverage) imposed under the CHIP state plan would also apply to premium assistance coverage. Parents would be permitted to disenroll their child(ren) from ESI coverage and enroll them in CHIP coverage effective on the first day of any month for which the child is eligible for such coverage.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

Each state has the option to establish an employer/family premium assistance purchasing pool for employers with less than 250 employees who have at least one CHIP-eligible employee (pregnant woman) or child.

The state, or a state designated entity, will identify and offer access to not less than two privately delivered health products that meet the CHIP benefits benchmark.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

This provision would not limit the state's authority to offer premium assistance under the Medicaid HIPP program, a section 1115 demonstration waiver, or any other authority in effect prior to the enactment of this Act. States would be required to inform parents about the availability of premium assistance subsidies for CHIP eligible children in qualified employer-sponsored insurance, how the family would elect such subsides during the application process and ensure that parents are fully informed of the choices for receiving child health assistance under the CHIP or through the receipt of a premium assistance subsidy.

The provision would also allow States to provide premium assistance subsidies for enrollment of targeted low-income children in coverage under a group health plan or health insurance coverage offered through an employer if it is determined that such coverage is actuarially equivalent to CHIP benchmark benefits coverage, or CHIP benchmark-equivalent coverage. Plans that meet the CHIP benefit coverage requirements would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under CHIP. Such provisions would be applied to Medicaid-eligible children and to the parents of Medicaid-eligible children in the same manner as they are applied to CHIP.

Finally, the provision would require the General Accountability Office to submit a report to the appropriate committees of Congress on cost and coverage issues relating to any State premium assistance programs for which federal matching payments are made under Medicaid, CHIP, or the Section 1115 waiver authority. Such report will be due to Congress no later than January 1, 2009.

SECTION 402. OUTREACH, EDUCATION, AND ENROLLMENT ASSISTANCE

Current Law

SCHIP states plans are required to include a description of the procedures in place to provide outreach to children eligible for SCHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of SCHIP coverage, and (2) to assist them in enrolling such children in SCHIP. In addition, states are required to provide a description of the state's efforts to ensure coordination between SCHIP and other public and private health coverage.

There is a limit on federal spending for SCHIP administrative expenses, which include activities such as data collection and

reporting, as well as outreach and education. For federal matching purposes, a 10% cap applies to state administrative expenses. This cap is tied to the dollar amount that a state draws down from its annual allotment to cover benefits under SCHIP, as opposed to 10% of a state's total annual allotment. In other words, no more than 10% of the federal funds that a state draws down for SCHIP benefit expenditures can be used for administrative expenses.

Explanation of Provision

The provision would require states to include a description of the procedures in place to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under CHIP or a waiver approved under Section 1115. For employers likely to provide qualified employer-sponsored coverage, the state is required to include the specific resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the CHIP state plan. Expenditures for such outreach activities would not be subject to the 10 percent limit on spending for administrative costs associated with the CHIP program.

Subtitle B—Coordinating Premium Assistance With Private Coverage

SECTION 411. SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR ASSISTANCE IN PURCHASE OF EMPLOYMENT-BASED COVERAGE

Current Law

Under the Internal Revenue Code, a group health plan is required to provide special enrollment opportunities to qualified individuals. Special enrollment refers to the opportunity given to qualified individuals to enroll in a health plan without having to wait until a late enrollment opportunity or open season. Such individuals must have lost eligibility for other group coverage, or lost employer contributions towards health coverage, or added a dependent due to marriage, birth, adoption, or placement for adoption. In addition, the individual must meet the health plan's substantive eligibility requirements, such as being a full-time worker or satisfying a waiting period. Health plans must give qualified individuals at least 30 days after the qualifying event (e.g., loss of eligibility) to make a request for special enrollment.

The same special enrollment opportunities apply to group health plans and health insurance issuers offering group health insurance under the Employee Retirement Income Security Act.

The Employee Retirement Income Security Act specifies the persons who may bring civil action to enforce the provisions under this statute. Such persons include a plan participant or beneficiary, a fiduciary, the Secretary of Labor, and a State. Current law allows the Secretary to assess a maximum financial penalty.against a plan administrator or employer for certain violations, including failure to meet the existing notice requirement.

Explanation of Provision

The provision would require (under the Internal Revenue Code) a group health plan to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. For compliance purposes, the employer may use any State-specific model notice issued by the Secretary of Labor or the Secretary of Health and Human Services in accordance with the model notice requirements established under this section of the bill.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The provision includes conforming amendments. A group health plan and a health insurance issuer offering group health insurance (under the Employee Retirement Income Security Act) would be required to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. Not later than 1 year after the date of enactment, the Secretary of Labor and the Secretary of Health and Human Services (HHS), in consultation with State Medicaid Directors and State CHIP Directors, would be required to develop model notices to enable employers to comply with notice requirements in a timely manner. Model notices would include information regarding how an employee would contact the State for information regarding premium assistance and how to apply for such assistance.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The HHS Secretary and the Labor Secretary would be required to jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group not later than 60 days after the date of enactment. The purpose of the Working Group would be to develop the model coverage coordination disclosure form, and to identify the impediments to effective coordination of coverage available to families. The purpose of the disclosure form would be to allow the State to determine the availability and cost-effectiveness of coverage, and allow for coordination of coverage for enrollees of such plans. The forms will include (1) information that will allow for the determination of an employee's eligibility for coverage under the group health plan, (2) the name and contact information of the plan administrator of the group health plan, (3) benefits offered under the plan, (4) premiums and cost-sharing under the plan, and (5) any other information relevant to coverage under the plan.

The Working Group would consist of no more than 30 members and be composed of representatives from the Department of Labor, the Department of Health and Human Services, State directors of Medicaid and CHIP programs, employers (including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals), plan administrations and plan sponsors of group health plans, and children and other beneficiaries of Medicaid and CHIP. Members would be required to serve without compensation. The Department of Health and Human Services and the Department of Labor would be required to jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group would be required to submit the model coverage coordination disclosure form, along with a report containing recommendations for appropriate measures to address impediments to effective coordination of coverage between Medicaid, CHIP and group health plans, to the Labor Secretary and the HHS Secretary no later than 18 months after the date of enactment. The Secretaries shall jointly submit a report regarding the Working Group report recommendations to each chamber of the Congress no later than 2 months after receipt of the report from the Working Group. The Working Group shall terminate 30 days after the issuance of its report.

The Labor Secretary and the HHS Secretary would be required to develop the initial model notices, and the Labor Secretary would provide such notices to employers no later than 1 year after the date of enactment. Each employer would be required to provide initial annual notices to its employees beginning the first year after the date on which the model notices are first issued. The model coverage coordination disclosure form would also apply to requests made by States beginning the first year after the date on which the model notices are first issued.

The provision would amend current law by allowing the Labor Secretary to assess a civil penalty (up to $100 a day) against an employer for failure to meet the new notice requirement established under this section of the bill. Each violation with respect to any employee would be treated as a separate violation. The Labor Secretary would also be allowed to assess a civil penalty (up to $100 a day) against a plan administrator for failure to comply with the new disclosure requirement established under this section of the bill. Each violation with respect to any participant or beneficiary would be treated as a separate violation.

Title V—Strengthening Quality of Care and Health Outcomes of Children

SECTION 501. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP

Current Law

The Centers for Medicare and Medicaid Services (CMS) and the Agency for

Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children.

In November 2002, CMS started the Quality Initiative (QI), a multi-faceted effort to improve health care quality. This program includes the Nursing Home Quality Initiative, the Home Health Quality Initiative, the National Voluntary Hospital Quality Reporting Initiative, and the Physician Focused Quality Initiative. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included provisions for hospitals to report data on quality indicators. In addition, the MMA included a variety of provisions designed to promote quality care, such as demonstrations that focus on improving the treatment of chronic illnesses and on identifying effective approaches for rewarding superlative performance. In 2005, quality reporting was expanded for inpatient hospital services and extended to home health. The development of plans for value-based purchasing in hospitals and home health settings was also required. In 2006, quality reporting was extended to hospital outpatient services and ambulatory service centers. Additionally, the 2007 Physician Quality Reporting Initiative (PQRI) implemented a voluntary quality reporting system for physicians and other eligible professionals with incentive payments for covered professional services tied to the reporting of claims data.

None of the CMS QI programs to date have focused on children. Rather, most have focused on the general population, adults with chronic conditions, or the frail elderly.

AHRQ has made quality improvement for children a priority in recent years. In part, this is because of the high costs incurred by children on Medicaid/SCHIP.

Many AHRQ projects to implement and evaluate improved health care strategies for the care of children are underway. These include:

1. Pediatric Quality Indicators that includes a set of measures that can be used with hospital inpatient discharge data to detect patient safety events and potentially avoidable hospitalizations.

2. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Medicaid uses CAHPS to measure quality of care for children with special health care needs.

3. AHRQ's Child Health Care Quality Toolbox lists tips and tools for evaluating health care quality for children. It is available to providers and consumers at www.ahrq.gov/chtoolbx/index.htm.

Other AHRQ-supported initiatives to improve the quality and safety of health care for children and adolescents, focusing on health care IT, and the development of pediatric electronic medical records, among other quality improvement activities.

Explanation of Provision

(a) Development of Child Health Quality Measures For Children Enrolled in Medicaid or CHIP.

The provision would add a new section to the Social Security Act defining child health quality improvement activities for children enrolled in Medicaid and CHIP. Not later than January 1, 2009, the Secretary would be required to identify and publish for general comment an initial recommended core set of child health quality measures for use by states with respect to Medicaid and CHIP, health insurance issuers and managed care entities that enter into contracts under Medicaid and CHIP, and providers under those two programs.

With consultation with specific groups (identified below), the Secretary must identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time. Based on such measures, the Secretary published an initial core set of child health quality measures that includes, but is not limited to, the following: (1) duration of insurance coverage over a 12-month period, (2) availability of a full range of preventive services, treatments, and services for acute conditions, including services to promote healthy birth and prevent and treat premature birth, and treatments to correct or ameliorate the effects of chronic physical and mental conditions, (3) availability of care in a range of ambulatory and inpatient settings, and (4) measures that, taken together, can be used to estimate the overall national quality of health care for children and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

Not later than 2 years after the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with the states, must develop a standardized format for reporting information and procedures and approaches that encourage states to use the initial core measurement set to voluntarily report information regarding quality of pediatric care under Medicaid and CHIP.

In addition, the Secretary must disseminate information to states regarding best practices with respect to measuring and reporting quality of care for children, and must facilitate adoption of such best practices. In developing these best practices approaches, the Secretary must give particular attention to state measurement techniques that ensure timeliness and accuracy of provider reporting, encourage provider reporting compliance and encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

Not later than January 1, 2010, and every 3 years thereafter, the Secretary must report to Congress on (1) the status of the Secretary's efforts to improve quality related to the duration and stability of health insurance coverage for children under Medicaid and CHIP, (2) the quality of children's health care under those programs, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions, as well as to aid in growth and development of children, and (3) quality of children's health care, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care. In these reports to Congress, the Secretary must also describe the status of voluntary reporting by states under Medicaid and CHIP utilizing the initial core set of quality measures, and provide any recommendations for legislative changes needed to improve quality of care provided to Medicaid and CHIP children, including recommendations for quality reporting by states. The Secretary must also provide technical assistance to states to assist them in adopting and utilizing core child health quality measures for their Medicaid and CHIP programs.

The provision defines ''core set'' to mean a group of valid, reliable and evidence-based quality measures for children that provide information regarding the quality of health coverage and health care for children, address the needs of children throughout the developmental age span, and that allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services to correct or ameliorate physical, mental or developmental conditions that could become chronic if left untreated or poorly treated.

(b) Advancing and Improving Pediatric Quality Measures.

The provision would also require the Secretary to establish a pediatric quality measures program not later than January 1, 2010. The purpose of this program would be to (1) improve and strengthen the initial core child health care quality measures, (2) expand on existing pediatric quality measures used by both public and private purchasers and advance the development of new and emerging measures, and (3) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchases of children's health care services, providers and consumers.

At a minimum, the pediatric quality measures developed under this program must be (1) evidence-based and where appropriate, risk-adjusted, (2) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care, (3) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparisons at the state, plan and provider level, (4) periodically adjusted, and (5) responsive to child health needs, services and stability of coverage.

In identifying gaps in existing pediatric quality measures and establishing priorities for the development and use of such measures, the Secretary must consult with a variety of entities, including (1) states, (2) institutional and non-institutional providers that specialize in the care and treatment of children, particularly those with special needs, (3) dental professionals, including pediatric dental professionals, (4) primary care providers for children and families living in medically under-served areas, or who are members of population subgroups at heightened risk for poor health outcomes, (5) national organizations representing consumers and purchasers of children's health care, (6) national organizations and individuals with expertise in pediatric health quality measurement, and (7) voluntary consensus standard setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

In addition, the Secretary must award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality identified above, and must also award grants and contracts for the (1) development of consensus on evidence-based measures for children's health care services, (2) dissemination of such measures to public and private purchasers of health care for children, and (3) updating of such measures as necessary.

Beginning no later than January 1, 2012 and annually thereafter, the Secretary must publish recommended changes to the core measures described above that must reflect the testing, validation, and consensus process for the development of pediatric quality measures also described above.

The term ''pediatric quality measure'' means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess one or

more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

(c) Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid or CHIP.

Each state with an approved state plan for Medicaid or CHIP must report annually to the Secretary the following: (1) state-specific child health quality measures, including measures of duration and stability of insurance coverage; quality with respect to preventive services and care for acute and chronic conditions as well as services to ameliorate the effects of physical and mental conditions, and to aid in growth and development; clinical quality, health care safety, family experience with health care, care delivered in the most integrated setting, and elimination of racial, ethnic and socioeconomic disparities in health care; and other measures in the initial core quality measurement set identified above, and (2) state-specific information on the quality of care provided to children under Medicaid and CHIP, including information collected through external quality reviews of Medicaid managed care organizations (under Section 1932) and Medicaid benchmark plans (under Section 1937), and CHIP benchmark plans (under Section 2103). Not later than September 30, 2009, and annually thereafter, the Secretary must collect, analyze and make publicly available the information reported by states as described above.

(d) Demonstration Projects for Improving the Quality of Children's Health Care and the Use of Health Information Technology.

During FY2008 through FY2012, the Secretary must award not more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care furnished under Medicaid and CHIP. Such projects would include efforts designed to: (1) experiment with and evaluate new measures of the quality of children's health care (including testing the validity and suitability for reporting of such measures), (2) promote the use of health information technology in care delivery for children, (3) evaluate provider-based models that improve the delivery of services to children, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety and efficiency of health care for children, or (4) demonstrate the impact of the model electronic health record format for children on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

In awarding these grants, the Secretary must ensure that (1) only one demonstration project funded by such a grant shall be conducted in a state, and (2) such demonstration projects must be conducted evenly between states with large urban areas and states with large rural areas. Grants may be conducted on a multi-state basis, as needed.

Of the total amount appropriated for this new grant program for a fiscal year (described below), $20 million must be used to carry out these activities.

(e) Demonstration Projects for Reducing Childhood Obesity

Current Law

Greater awareness of the obesity crisis and its long-term social and economic implications has encouraged policy makers to fund an array of programs aimed at promoting physical activity and appropriate nutrition. While many of these have been state-based efforts, the federal government has actively funded obesity research as well as health promotion campaigns and public health surveillance systems.

Title III of the Public Health Service Act (42 USC) obliges the Secretary of Health and Human Services to ''conduct . . . encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, and demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments''. In carrying out these responsibilities, the Secretary is authorized to make grants-in-aid to universities, hospitals, laboratories, other public or private institutions, and to individuals for research projects.

The National Academy of Sciences (NAS) recently noted that the fundamental problem plaguing national programs seeking to address the obesity crisis is that these efforts ''remain fragmented and small-scale''. Moreover, obesity prevention programs remain largely uncoordinated. Although many federal agencies are involved in overseeing different types of obesity-related programs, including the Centers for Disease Control and Prevention (CDC), the Department of Agriculture, the National Institutes of Health, and Department of Health and Human Services, NAS concluded that the lack of a dedicated funding stream for obesity prevention and inadequate coordination between federal agencies has led to inefficient uses of resources or unnecessary redundancies in programmatic efforts.

Another problem is that many federal funding streams available to support healthy lifestyles among children have been very narrowly focused on small target populations or they have only addressed obesity indirectly. Examples of the former include efforts which have exclusively targeted low-income families (usually, Medicaid recipients); by contrast, health education courses aimed at American Indians with Type 2 diabetes exemplify the types of federally-funded efforts which have indirectly served as obesity prevention programs but which have reached very limited numbers of individuals in the aggregate.

Explanation of Provision

The Secretary, in consultation with the Administrator of the Centers for Medicare a Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such a project. The model will (1) identify behavioral risk factors for obesity among children; (2) identify needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors; (3) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and (4) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under CHIP and Medicaid.

Eligible entities include a city, county, or Indian tribe; a local or tribal educational agency; an accredited university, college, or community college; a federally-qualified health center; a local health department; a health care provider; a community-based organization; or any other entity determined appropriate by the Secretary, including a consortium or partnership.

An eligible entity awarded a grant under this provision shall use the funds to (1) carry out community-based activities related to reducing childhood obesity, (2) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, (3) carry out educational, counseling, promotional, and training activities through the local health care delivery systems, and (4) provide, through qualified health professionals, training and supervision for community health workers to engage in educational efforts related to obesity.

Not later than 3 years after the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates beneficiary satisfaction under the project, and includes any other information the Secretary deems appropriate. $25 million is authorized for this purpose.

(f) Development of Model Electronic Health Record Format for Children Enrolled in Medicaid or CHIP.

Not later than January 1, 2009, the Secretary must establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled under state plans for Medicaid or CHIP. Such an electronic health record would be (1) subject to state laws, accessible to parents, caregivers and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, (2) designed to allow interoperable exchanges that conform with federal and state privacy and security requirements, (3) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality, and (4) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records. Of the total amount appropriated for this new grant program for a fiscal year, $5 million must be used to carry out these activities.

(g) Study of Pediatric Health and Health Care Quality Measures.

Not later than July 1, 2009, the Institute of Medicine must study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments to ameliorate or correct physical, mental, and developmental conditions in children. In conducting this study, the IOM must: (1) consider all the major national population-based reporting systems sponsored by the federal government, including reporting requirements under federal grant programs and national population surveys and estimates conducted directly by the federal government, (2) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information is made widely available through publication, (3) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment, and (4) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care

quality. Of the total amount appropriated for this new grant program, up to $1 million must be used to carry out these activities.

(h) Rule of Construction.

No evidence-based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving assistance under Medicaid or CHIP.

(i) Appropriations.

An appropriation of $45 million for FY2008 through FY2012 would be made for the purpose of carrying out the provisions of this section. Such funds would remain available until expended.

The provision would also use the federal medical assistance percentage (FMAP) applicable to a given state to determine the federal share of costs incurred by states for the development or modification of existing claims processing and retrieval systems as is necessary for the efficient collection and reporting on child health measures.

SECTION 502. IMPROVED INFORMATION REGARDING ACCESS TO OVERAGE UNDER CHIP

Current Law

Under SCHIP, states must assess the operation of the SCHIP state plan in each fiscal Year, including the progress made in reducing the number of uncovered low-income children. They must also report to the Secretary of HHS, by January 1 following the end of the fiscal year, the results of that assessment.

Federal regulations stipulate that each annual report include the following additional information: (1) progress in meeting strategic objectives and performance goals identified in the state SCHIP plan, (2) effectiveness of policies to discourage the institution of public coverage for private coverage, (3) identification of successes and barriers in state plan design and implementation, and the approaches the state is considering to overcome these barriers, (4) progress in addressing any specific issues (such as outreach) that the state plan proposed to periodically monitor and assess, (5) an updated 3–year budget, including any changes in the sources of non-federal share of state pan expenditures, (6) identification of total state expenditures for family coverage and total number of children and adults, respectively, provided family coverage during the preceding fiscal year, and (7) current income standards and methodologies for its SCHIP Medicaid expansion program, separate SCHIP program, and its regular Medicaid program, as appropriate.

Explanation of Provision

(a) Inclusion of Process and Access Measures in Annual State Reports.

The provision would require each state to include the following information in its annual CHIP report to the Secretary of HHS: (1) eligibility criteria, enrollment, and retention data (including information on continuity of coverage or duration of benefits), (2) data regarding the extent to which the state uses process measures with respect to determining the eligibility of children, including measures such as 12–months of continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility, (3) data regarding denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the state CHIP plan, using quality of care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, (5) if the state provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for CHIP, the range of the monthly amount of such assistance provided on behalf or a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the state CHIP plan to supplement the coverage purchased with such premium assistance, the effective strategies the state engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage under CHIP from substituting for coverage provided under employer-sponsored health insurance offered in the state, and (6) to the extent applicable, a description of any state activities that are designed to reduce the number of uncovered children in the state, including through a state health insurance connector program or support for innovative private health coverage initiatives.

(b) GAG Study and Report on Access to Primary and Specialty Services.

The provision would require GAO to conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including (1) the extent to which providers are willing to treat children eligible for such programs, (2) information on such children's access to networks of care, (3) geographic availability of primary and specialty services under such programs, (4) the extent to which care coordination is provided for children's care under Medicaid and CHIP, and (5) as appropriate, information on the degree of availability of services for children under such programs.

In addition, not later than 2 years after the date of enactment of this Act, GAO must submit a report to the appropriate committees of Congress on this study that includes recommendations for such federal and state legislative and administrative changes as GAO determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

SECTION 503. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP

Current Law

A number of sections of the Social Security Act apply to states under title XXI (SCHIP) in the same manner as they apply to a state under title XIX (Medicaid). These include:

Section 1902(a)(4)(C) (relating to conflict of interest standards).

Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

Section 1903(w) (relating to limitations on provider taxes and donations).

Section 1920A (relating to presumptive eligibility for children).

Explanation of Provision

The provision would add the same requirements for CHIP managed care entities as currently exist under Medicaid. Specifically, the provision would add reference to Medicaid's statutory requirements on: the process for plan enrollment, termination, and change of enrollment; the type of information provided to enrollees and potential enrollees on providers, covered services, enrollee rights, and other forms of information; beneficiary protections; quality assurance standards; protections against fraud and abuse; and sanctions against managed care plans for noncompliance.

Title VI—Miscellaneous

SECTION 601. TECHNICAL CORRECTION REGARDING CURRENT STATE AUTHORITY UNDER MEDICAID

Current Law

States may provide SCHIP through an expansion of their Medicaid programs. Expenditures for such populations of targeted low-income children are matched at the enhanced FMAP rate and are paid out of SCHIP allotments.

Explanation of Provision

With respect to expenditures for Medicaid for fiscal years 2007 and 2008 only, a state may elect (1) to cover optional poverty-related children and, may apply less restrictive income methodologies to such individuals (via authority in Section 1902(r) or through Section 1931 (b)(2)(C)), for which the regular Medicaid FMAP, rather than the enhanced FMAP applicable to CHIP, would be used to determine the federal share of such expenditures, or (2) to receive the regular Medicaid FMAP, rather than the enhanced CHIP FMAP, for CHIP children under an expansion of the state's Medicaid program. This provision would be repealed as of October 1, 2008 (i.e., the beginning of fiscal year 2009). States electing these options would be ''held harmless'' for related expenditures in FY2007 and FY2008, once this repeal takes effect.

SECTION 602. PAYMENT ERROR RATE MEASUREMENT (''PERM'')

Current Law

P.L. 107–300 requires the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures.

The Center for Medicare and Medicaid Services (CMS), the federal agency within HHS that administers the Medicaid and SCHIP programs, issued an interim final rule with comment period on August 28, 2006, regarding Payment Error Rate Measurement (PERM) for the Medicaid and SCHIP programs. This rule was effective on October 1, 2006. In addition to P.L. 107–300, this regulation points to Sections 1102, 1902(a)(6) and 2107(b)(1) of the Social Security Act which contains the Secretary's general rulemaking authority and obligation of the states to provide information, as the Secretary may require, to monitor program performance. Section 1902(a)(27)(B) also requires states to require providers to furnish State Medicaid Agencies and the Secretary with information regarding payments claimed by Medicaid providers for furnishing Medicaid services. Payment error rates will be calculated for fee-for-service (FFS) claims, managed care claims and for eligibility determinations. The preamble to this regulation notes that CMS will hire Federal contractors to review Medicaid and SCHIP FFS and managed care claims and to calculate the state-specific and national error rates for both programs. States will calculate the state-specific eligibility error rates. Based on those rates, the Federal contractor will calculate the national eligibility error rate for each program. CMS plans to sample a subset of states each year rather than measure every state every year.

With respect to Medicaid and SCHIP eligibility reviews under PERM, states selected for review in a given year must conduct reviews of a statistically valid random sample of beneficiary claims to determine if improper payments were made based on errors in the state agency's eligibility determinations. States must have a CMS-approved sampling plan. In addition to reporting error

rates, states must also submit a corrective action plan based on its error rate analysis, and must return overpayments of federal funds.

Medicaid Eligibility Quality Control (MEQC) is operated by State Medicaid agencies to monitor and improve the administration of its Medicaid program. The traditional MEQC program is based on State reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from the eligibility files. These reviews are conducted to determine whether the sampled cases meet applicable Title XIX eligibility requirements and to determine if a State has made erroneous excess payments in its program. ''Erroneous excess payments for medical assistance'' reflect: a) payments made on behalf of ineligible individuals and families, and b) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

The SCHIP statute specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Explanation of Provision

The provision would apply a federal matching rate of 90 percent to expenditures related to administration of PERM requirements applicable to CHIP.

The provision would also exclude from the 10% cap on CHIP administrative costs all expenditures related to the administration of PERM requirements applicable to CHIP in accordance with P.L. 107–300, existing regulations, and any related or successor guidance or regulations.

In addition, the Secretary must not calculate or publish any national or state-specific error rate based on the application of PERM requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements (described below) is in effect for all states. Any calculation of a national error rate or a state specific error rate after such a final rule is in effect for all states may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

The final rule implementing the PERM requirements must include: (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

After the final PERM rule is in effect for all states, a state for which the PERM requirements were first in effect under an interim final rule for FY2007 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year or may elect to not have an payment error rate determined on the basis of such data and, instead, must be treated as if FY2010 were the first year for which the PERM requirements apply to the state.

If the final PERM rule is not in effect for all states by July 1, 2008, a state for which the PERM requirements were first in effect under an interim final rule for FY2008 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year, or may elect to not have any payment error rate determined on the basis of such data and, instead, must be treated as if FY2011 were the first fiscal year for which the PERM requirements apply to the state.

In addition, the provision would require the Secretary to review the Medicaid Eligibility Quality Control (MEQC) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies. A state may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the state under MEQC, to substitute data resulting from the application of PERM requirements after the final PERM rule is in effect for all states for the data used for the MEQC requirements.

The Secretary must also establish state-specific sample sizes for application of the PERM requirements with respect to CHIP for FY2009 and thereafter, on the basis of information as the Secretary determines is appropriate. In establishing such sample sizes, the Secretary must, to the greatest extent possible (1) minimize the administrative cost burden on states under Medicaid and CHIP, and (2) maintain state flexibility to manage these programs.

SECTION 603. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT

Current Law

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll (for up to 2 months) children whose family income appears to be below applicable Medicaid income standards, until a formal determination of eligibility is made. Payments on behalf of Medicaid children during periods of presumptive eligibility are matched at the regular Medicaid FMAP, but are paid out of state SCHIP allotments.

Explanation of Provision

The provision would strike the language in existing CHIP statute that sets the federal share of costs incurred during periods of presumptive eligibility for children at the Medicaid FMAP rate, and also strikes the language that allows payment out of CHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility.

SECTION 604. IMPROVING DATA COLLECTION

Current Law

As discussed in Section 102, the percentage of the SCHIP appropriation that is allotted to individual states is based primarily on state-level estimates of (1) the number of low-income children and (2) the number of uninsured low-income children, based on a three-year average of the Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS). Based on these CPS estimates, some states' share of the available national allotment in the second year of SCHIP (FY1999) was going to differ markedly from the prior year's (e.g., a share of the available national allotment in FY1999 that would have been approximately 40% lower or higher than in FY1998). As a result, legislation was enacted to base the FY1999 SCHIP allotments on the states' share of the available national allotment as calculated for FY1998.

Separate legislation was also enacted to add two new floors and a ceiling to ensure that a state's share of the available national allotment did not change by more than certain amounts, as compared to the state's prior-year share and the state's FY1998/FY1999 share.

Another piece of legislation was also enacted that required appropriate adjustments to the CPS (1) to produce statistically reliable annual state data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected; (2) to produce data that categorizes such children by family income, age, and race or ethnicity; and (3) where appropriate, to expand the sample size used in the state sampling units, to expand the number of sampling units in a state, and to include an appropriate verification element. For this purpose, $10 million was appropriated annually, beginning in FY2000. Because of this legislation, the number of sampled households in the ASEC CPS increased by about 50% (34,500 households). Even with the sample expansion, the margins of error of the state-level estimates of the number of low-income children, and particularly the estimates of low-income children without health insurance, can be relatively high, especially in smaller states.

Explanation of Provision

Besides the $10 million provided annually for the CPS since FY2000, an additional $10 million (for a total of $20 million additionally) is appropriated. In addition to the current-law requirements of the additional appropriation, for data collection beginning in FY2008, in appropriate consultation with the HHS Secretary, the Secretary of Commerce shall do the following:

Make appropriate adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in CHIP or Medicaid;

Make appropriate adjustments to the CPS to improve the survey estimates used to compile the state-specific and national number of low-income children without health insurance for purposes of determining annual CHIP allotments, and for making payments to states from the CHIP Incentive Pool, the CHIP Contingency Fund, and, to the extent applicable to a State, from the block grant set aside for CHIP payments on behalf of parents in FY2010 through FY2012;

Include health insurance survey information in the American Community Survey (ACS) related to children;

Assess whether ACS estimates, once such survey data are first available, produce more reliable estimates than the CPS for CHIP allotments and payments;

On the basis of that assessment, recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for CHIP purposes; and

Continue making the adjustments to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

If the Commerce Secretary recommends to the HHS Secretary that ACS estimates should be used instead of, or in combination with, CPS estimates for CHIP purposes, the HHS Secretary may provide a transition period for using ACS estimates, provided that

the transition is implemented in a way that avoids adverse impacts on states.

SECTION 605. DEFICIT REDUCTION ACT TECHNICAL CORRECTION

State Flexibility in Benefit Packages.

Current Law

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most children under age 21 receive comprehensive basic screening services (i.e., well-child visits including age-appropriate immunizations) as well as dental, vision and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligible individuals.

Under Medicaid, categorically needy (CN) eligibility groups include families with children, the elderly, certain individuals with disabilities, and certain other pregnant women and children who meet applicable financial eligibility standards. Some CN eligibility groups must be covered while others are optional. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. All MN eligibility groups are optional.

The Deficit Reduction Act of 2005 (DRA; P.L. 109–171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to plans available under SCHIP (described above). For any child under age 19 in one of the major mandatory and optional CN eligibility groups (defined in Section 1902(a)(10)(A)), wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT (described above). In traditional Medicaid, EPSDT is available to individuals under age 21 in CN groups, and may be offered to individuals under 21 in MN groups.

DRA identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark equivalent plans. One such exempted group is children in foster care receiving child welfare services under Part B of title IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title.

Explanation of Provision

The provision would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state plan under one of the major mandatory and optional CN groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise.

The provision would also make a correction to the reference to children in foster care receiving child welfare services.

Finally, not later than 30 days after the date the Secretary approves a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid, the Secretary must publish in the Federal Register and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable the state to carry out such a state plan amendment and the reason for each such determination.

The amendments made by this provision would become effective as if included in Section 6044(a) of the DRA (i.e., March 31, 2006).

SECTION 606. ELIMINATION OF CONFUSING PROGRAM REFERENCES

Current Law

P.L. 106–113 directed the Secretary of HHS or any other Federal officer or employee, with respect to references to the program under Title XXI of the Social Security Act, in any publication or official communication to use the term ''SCHIP'' instead of ''CHIP'' and to use the term ''State children's health insurance program'' instead of ''children's health insurance program.''

Explanation of Provision

The provision would repeal the section in P.L 106–113 providing the program references to ''SCHIP'' and ''State children's health insurance program'' for official publication and communication purposes.

SECTION 607. MENTAL HEALTH PARITY IN CHIP PLANS

Current Law

In 1996, Congress passed the Mental Health Parity Act (MHPA) that established new federal standards for mental health coverage offered by group health plans, most of which are employment-based. Under provisions included in the 1997 Balanced Budget Act (P.L. 105–33), Medicaid managed care plans and SCHIP programs must comply with the requirements of MHPA.

Medicaid expansions under SCHIP follow Medicaid rules. Thus, when such expansions provide for enrollment in Medicaid managed care plans, the MHPA applies. Separate state programs under SCHIP follow SCHIP rules that have broader application than the Medicaid rules. In separate state SCHIP programs, to the extent that a health insurance issuer offers group health insurance coverage, which can include, but is not limited to managed care, the MHPA applies.

Under MHPA, Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.

Under Medicaid managed care, state Medicaid agencies contract with managed care organizations (MCOs) to provide a specified set of benefits to enrolled beneficiaries. These MCOs may be paid under a variety of arrangements, but are frequently reimbursed on the basis of a pre-determined monthly fee (called a capitation rate) for each enrolled beneficiary. The contracted benefits may include all, some, or none of the mandatory and optional mental health services covered under the state Medicaid plan. When Medicaid managed care plans do not include all covered mental health benefits, these additional services are sometimes ''carved out'' to a separate, specialized behavioral health managed care entity (usually subject to its own prepaid capitation rates), or may be provided in the fee-for-service setting, in which Medicaid providers are paid directly by the state Medicaid agency for each covered service delivered to a Medicaid beneficiary. All prepaid Medicaid managed care contracts that cover medical/surgical benefits and mental health benefits must comply with the MHPA without exemptions. The MHPA does not apply to fee-for-service arrangements because state Medicaid agencies do not meet the definition of a group health plan.

With respect to covered benefits, separate SCHIP programs tend to look more like private insurance models than like Medicaid. That is, these programs are more likely to cover traditional benefits (e.g., inpatient hospital services, physician services) that would be found in employer-based health insurance plans than certain service categories that are largely unique to Medicaid (e.g., EPSDT, residential treatment facilities, intermediate care facilities for the mentally retarded or ICF/MRs, and institutions for mental disease or IMDs). Most separate SCHIP programs also provide services through managed care plans, although this situation varies by state. Again, all or some covered mental health services may be included in MCO contracts, or carved out to specialized behavioral health managed care plans, or may be provided on a fee-for-service basis.

Under CHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

Explanation of Provision

This section prohibits discriminatory limits on mental health care in separate CHIP plans by directing that any financial requirements or treatment limitations that apply to mental health or substance abuse services must be no more restrictive than the financial requirements or treatment limits that apply to other medical services. It also eliminates a current law provision that authorizes states to reduce the mental health coverage provided to 75 percent of the coverage provided in CHIP benchmark plans.

SECTION 608. DENTAL HEALTH GRANTS

Current Law

Under SCHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

SCHIP regulations specify that, regardless of the type of SCHIP health benefits coverage, states must provide coverage of well-baby and well-child care (as defined by the state), age-appropriate immunizations based on recommendations of the Advisory Committee on Immunization Practices (ACIP), and emergency services.

Explanation of Provision

This section provides up to $200 million in federal grants for states to improve the availability of dental services and strengthen dental coverage for children covered under CHIP. States that receive grants would be required to maintain prior levels of spending for dental services provided under CHIP.

SECTION 609. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Current Law

Under current Medicaid law, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) are paid based on a prospective payment system. Beginning in FY2001, per visit payments were based on 100% of average costs during 1999 and 2000 adjusted for changes in the scope of services furnished. (Special rules applied to entities first established after 2000). For subsequent years, the per visit payment for all FQHCs and RHCs equals the amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services, and adjusted for any changes in the scope of services furnished during that fiscal year. In managed care contracts, states are required to make supplemental payments to the facility equal to the difference between the contracted amount and the cost-based amounts.

Explanation of Provision

This section would establish a prospective payment system in CHIP for FQHCs and RHCs similar to the payment system established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) applicable under Medicaid law. States that operate separate or combination CHIP programs would be required to reimburse FQHCs and RHCs based on the Medicaid Prospective Payment System, starting in FY 09. A one-time appropriation of $5 million will be made available to the Secretary of HHS to be provided to affected states to enable them to transition to the new payment system on the affected states. The Secretary would be required to monitor the impact of the application of the payment system on states and report to Congress within two years of implementation on any effect on access to benefits, provider payment rates, or scope of benefits offered by affected states.

Title VII—Revenue Provisions

Title VIII—Effective Date

SECTION 801. EFFECTIVE DATE

Current Law

No provision.

Explanation of Provision

The effective date of this bill except with respect to section 301 would be October 1, 2007, whether or not final regulations to carry out provisions in the bill have been promulgated by that date. In the case of both current state CHIP and Medicaid plans, if the Secretary of HHS determines that a state must pass new state legislation to implement the requirements of this bill, the state's existing CHIP and/or Medicaid plans, if applicable, would not be considered to be out of compliance solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this bill. In the case of a state that has a 2-year legislative session, each year of such session must be considered to be a separate regular session of the state legislature. With respect to section 301, the effective date will be October 1, 2008.

By Mr. REID (for Mr. DODD (for himself, Mr. NELSON of Nebraska, Mr. KENNEDY, Mr. REED, and Mr. LIEBERMAN)):

S. 1894. A bill to amend the Family and Medical Leave Act of 1993 to provide family and medical leave to primary caregivers of servicemembers with combat-related injuries; to the Committee on Health, Education, Labor, and Pensions.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

● Mr. DODD. Mr. President, I rise today to introduce the Support for Injured Servicemembers Act of 2007. This bill will implement one of the key recommendations of the President's Commission on Care for America's Returning Wounded Warriors. First of all, I commend former Senator Bob Dole, former Secretary of Health and Human Services Donna Shalala, and the distinguished members of the Commission for their thoughtfulness and thorough work on this critically important matter.

More than 20 years ago, I began the effort to bring job protection to hard-working Americans so they wouldn't have to choose between the family they love and the job they need. This effort, after more than seven years, three presidents, and two vetoes, eventually led to the enactment of the Family Medical Leave Act, FMLA, which provides 12 weeks of unpaid leave for eligible employees to care for a newborn or adopted child, their own serious illness or that of a loved one. Since its passage, I have worked to expand this act to cover more workers and to provide for wage replacement, so that more employees can afford to take leave when necessary.

Mr. President, it is essential that we do everything possible to support our troops and to allow their loved ones to be with them as they recover from a combat-related injury or illness. That is why we must expand and improve leave benefits to those caring for our injured or ill servicemembers. The bill I introduce today provides up to 6 months of FMLA leave for primary caregivers of servicemembers who suffer from a combat-related injury or illness. FMLA currently provides for 3 months of unpaid leave to a spouse, parent or child acting as a caregiver for a person with a serious illness. However, some of those injured in service to our country rely on other family members or friends to care for them as they recover. This legislation allows these other primary caregivers, such as siblings, cousins, friends or significant others to take leave from their employment when our returning heroes need them most.

Our troops are giving their all on the battlefield. The very least our Government owes them is its total support for their family and medical needs. While FMLA has provided critical support to more than 50 million American families, I will not rest until we are able to modernize this statute to cover our wounded warriors. Plain and simple, the loved ones of these brave men and women should be allowed to care for them without the fear of losing their job.

I am pleased that I am joined today by Senators BEN NELSON, KENNEDY, REED and LIEBERMAN in introducing the Support for Injured Servicemembers Act of 2007 and ask for the support of all my colleagues for this critically important effort to care for our returning wounded warriors and their loved ones.

I ask unanimous consent that the text of the bill be printed in the RECORD. ●

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

S. 1894

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Support for Injured Servicemembers Act of 2007''.

SEC. 2. SERVICEMEMBER FAMILY LEAVE.

(a) DEFINITIONS.—Section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) is amended by adding at the end the following:

''(14) COMBAT-RELATED INJURY.—The term 'combat-related injury' means an injury or illness that was incurred (as determined under criteria prescribed by the Secretary of Defense)—

''(A) as a direct result of armed conflict;

''(B) while an individual was engaged in hazardous service;

''(C) in the performance of duty under conditions simulating war; or

''(D) through an instrumentality of war.

''(15) SERVICEMEMBER.—The term 'servicemember' means a member of the Armed Forces.''.

(b) ENTITLEMENT TO LEAVE.—Section 102(a) of such Act (29 U.S.C. 2612(a)) is amended by adding at the end the following:

''(3) SERVICEMEMBER FAMILY LEAVE.—Subject to section 103, an eligible employee who is the primary caregiver for a servicemember with a combat-related injury shall be entitled to a total of 26 workweeks of leave during any 12-month period to care for the servicemember.

''(4) COMBINED LEAVE TOTAL.—An eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs (1) and (3).''.

(c) REQUIREMENTS RELATING TO LEAVE.—

(1) SCHEDULE.—Section 102(b) of such Act (29 U.S.C. 2612(b)) is amended—

(A) in paragraph (1), by inserting after the second sentence the following: ''Subject to paragraph (2), leave under subsection (a)(3) may be taken intermittently or on a reduced leave schedule''; and

(B) in paragraph (2), by inserting ''or subsection (a)(3)'' after ''subsection (a)(1)''.

(2) SUBSTITUTION OF PAID LEAVE.—Section 102(d) of such Act (29 U.S.C. 2612(d)) is amended—

(A) in paragraph (1)—

(i) by inserting ''(or 26 workweeks in the case of leave provided under subsection (a)(3))'' after ''12 workweeks'' the first place it appears; and

(ii) by inserting ''(or 26 workweeks, as appropriate)'' after ''12 workweeks'' the second place it appears; and

(B) in paragraph (2)(B), by adding at the end the following: ''An eligible employee

may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, family leave, or medical or sick leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.''.

(3) NOTICE.—Section 102(e) of such Act (29 U.S.C. 2612(e)) is amended by adding at the end the following:

''(3) NOTICE FOR SERVICEMEMBER FAMILY LEAVE.—In any case in which an employee seeks leave under subsection (a)(3), the employee shall provide such notice as is practicable.''.

(4) CERTIFICATION.—Section 103 of such Act (29 U.S.C. 2613) is amended by adding at the end the following:

''(f) CERTIFICATION FOR SERVICEMEMBER FAMILY LEAVE.—An employer may require that a request for leave under section 102(a)(3) be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe.''.

(5) FAILURE TO RETURN.—Section 104(c) of such Act (29 U.S.C. 2614(c)) is amended—

(A) in paragraph (2)(B)(i), by inserting ''or section 102(a)(3)'' before the semicolon; and

(B) in paragraph (3)(A)—

(i) in clause (i), by striking ''or'' at the end;

(ii) in clause (ii), by striking the period and inserting ''; or''; and

(iii) by adding at the end the following:

''(iii) a certification issued by the health care provider of the person for whom the employee is the primary caregiver, in the case of an employee unable to return to work because of a condition specified in section 102(a)(3).''.

(6) ENFORCEMENT.—Section 107 of such Act (29 U.S.C. 2617) is amended, in subsection (a)(1)(A)(i)(II), by inserting ''(or 26 weeks, in a case involving leave under section 102(a)(3))'' after ''12 weeks''.

(7) INSTRUCTIONAL EMPLOYEES.—Section 108 of such Act (29 U.S.C. 2618) is amended, in subsections (c)(1), (d)(2), and (d)(3), by inserting ''or section 102(a)(3)'' after ''section 102(a)(1)''.

SEC. 3. SERVICEMEMBER FAMILY LEAVE FOR CIVIL SERVICE EMPLOYEES.

(a) DEFINITIONS.—Section 6381 of title 5, United States Code, is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(7) the term 'combat-related injury' means an injury or illness that was incurred (as determined under criteria prescribed by the Secretary of Defense)—

''(A) as a direct result of armed conflict;

''(B) while an individual was engaged in hazardous service;

''(C) in the performance of duty under conditions simulating war; or

''(D) through an instrumentality of war; and

''(8) the term 'servicemember' means a member of the Armed Forces.''.

(b) ENTITLEMENT TO LEAVE.—Section 6382(a) of such title is amended by adding at the end the following:

''(3) Subject to section 6383, an employee who is the primary caregiver for a servicemember with a combat-related injury shall be entitled to a total of 26 administrative workweeks of leave during any 12-month period to care for the servicemember.

''(4) An employee shall be entitled to a combined total of 26 administrative workweeks of leave under paragraphs (1) and (3).''.

(c) REQUIREMENTS RELATING TO LEAVE.—

(1) SCHEDULE.—Section 6382(b) of such title is amended—

(A) in paragraph (1), by inserting after the second sentence the following: ''Subject to paragraph (2), leave under subsection (a)(3) may be taken intermittently or on a reduced leave schedule.''; and

(B) in paragraph (2), by inserting ''or subsection (a)(3)'' after ''subsection (a)(1)''.

(2) SUBSTITUTION OF PAID LEAVE.—Section 6382(d) of such title is amended by adding at the end the following: ''An employee may elect to substitute for leave under subsection (a)(3) any of the employee's accrued or accumulated annual or sick leave under subchapter I for any part of the 26-week period of leave under such subsection.''.

(3) NOTICE.—Section 6382(e) of such title is amended by adding at the end the following:

''(3) In any case in which an employee seeks leave under subsection (a)(3), the employee shall provide such notice as is practicable.''.

(4) CERTIFICATION.—Section 6383 of such title is amended by adding at the end the following:

''(f) An employing agency may require that a request for leave under section 6382(a)(3) be supported by a certification issued at such time and in such manner as the Office of Personnel Management may by regulation prescribe.''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 281—CONGRATULATING CAL RIPKEN JR. FOR HIS INDUCTION INTO THE BASEBALL HALL OF FAME, FOR AN OUTSTANDING CAREER AS AN ATHLETE, AND FOR HIS CONTRIBUTIONS TO BASEBALL AND TO HIS COMMUNITY

Ms. MIKULSKI (for herself, Mr. CARDIN, and Mr. SCHUMER) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 281

Whereas Cal Ripken, Jr. was born and raised in Maryland;

Whereas Cal Ripken, Jr. was elected to the Baseball Hall of Fame on January 9, 2007, his first year of eligibility, for his outstanding accomplishments during his 21-year career in Major League Baseball;

Whereas Cal Ripken, Jr. will be inducted into the Baseball Hall of Fame on July 29, 2007, along with fellow baseball legend Tony Gwynn;

Whereas Cal Ripken, Jr. was nearly unanimously elected to the Baseball Hall of Fame with the highest number of votes ever received for a regular position player;

Whereas Cal Ripken, Jr. is widely considered the ''Iron Man'' of baseball, having earned this moniker by playing in 2,632 consecutive games, a feat unmatched in professional sports;

Whereas Cal Ripken, Jr. was the American League Rookie of the Year in 1982;

Whereas Cal Ripken, Jr. had 3,184 career hits and 431 home runs and received 8 Silver Slugger Awards for his superior offensive play;

Whereas Cal Ripken, Jr. is first among the all-time Baltimore Orioles career leaders in total games played, consecutive games played, at bats, hits, runs, runs batted in, extra base hits, doubles, home runs, total bases, walks, strikeouts, assists, and double plays;

Whereas Cal Ripken, Jr. is first among all Major League Baseball players in the number of consecutive games played and the number of double plays by a shortstop;

Whereas Cal Ripken, Jr. is the all-time leader in Major League Baseball All-Star fan balloting, has made the most Major League Baseball All-Star Game appearances at shortstop, and has made the most consecutive Major League Baseball All-Star Game starts;

Whereas Cal Ripken, Jr. has not only proven to be a great hitter but a great defensive player, winning 2 Gold Glove awards;

Whereas Cal Ripken, Jr. was selected to play on 19 All-Star teams throughout his career and was twice voted All-Star Game Most Valuable Player;

Whereas Cal Ripken, Jr. helped the Baltimore Orioles win the World Series in 1983;

Whereas, in an era when money dominated the game of baseball, Cal Ripken, Jr. chose to play in Baltimore for the Baltimore Orioles when it was believed that he could have earned more money with another team in another city;

Whereas Cal Ripken, Jr. is an example of good sportsmanship who has always conducted himself with dignity;

Whereas Cal Ripken, Jr. is a role model for young people and for all the people of the United States;

Whereas Cal Ripken, Jr., along with his family and the Ripkin Baseball organization, is a philanthropist dedicated to the Cal Ripken Sr. Foundation, which gives underprivileged children the opportunity to attend baseball camps around the country;

Whereas Cal Ripken, Jr. operates baseball camps and designs baseball fields for youth, college, and professional teams;

Whereas Cal Ripken, Jr. gives speeches about his time in baseball and some of the lessons he has learned;

Whereas, in 1992, Cal Ripken, Jr. was awarded Major League Baseball's Roberto Clemente Man of the Year Award and the Lou Gehrig Memorial Award for his community involvement; and

Whereas Cal Ripken, Jr. has been selected for the Major League Baseball All-Century Team: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Cal Ripken, Jr. for his election to the Baseball Hall of Fame;

(2) honors Cal Ripkin, Jr. for an outstanding career as an athlete; and

(3) thanks Cal Ripkin, Jr. for his contributions to baseball and to his community.

SENATE RESOLUTION 282—SUPPORTING THE GOALS AND IDEALS OF A NATIONAL POLYCYSTIC KIDNEY DISEASE AWARENESS WEEK TO RAISE PUBLIC AWARENESS AND UNDERSTANDING OF POLYCYSTIC KIDNEY DISEASE AND TO FOSTER UNDERSTANDING OF THE IMPACT POLYCYSTIC KIDNEY DISEASE HAS ON PATIENTS AND FUTURE GENERATIONS OF THEIR FAMILIES

Mr. KOHL (for himself, Mr. HATCH, submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 282

Whereas polycystic kidney disease (known as ''PKD'') is 1 of the most prevalent life-threatening genetic diseases in the United States, is a severe, dominantly inherited disease that has a devastating impact, in both human and economic terms, on people of all ages, and affects equally people of all races, sexes, nationalities, geographic locations, and income levels;