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

SA 2966. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2967. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2968. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2969. Mr. COBURN (for himself, Mr. GRASSLEY, Mr. BURR, Mr. VITTER, Mrs. MCCASKILL, and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2970. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2971. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2972. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2973. Mrs. MURRAY (for herself and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2974. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2975. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2976. Mr. CARDIN (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2977. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2978. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2979. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2980. Ms. MIKULSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2981. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2982. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2983. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2984. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2985. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2986. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2987. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2988. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2989. Mr. MENENDEZ (for himself, Mr. SCHUMER, Mr. DODD, Mrs. GILLIBRAND, Mr. KERRY, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2990. Mr. MENENDEZ submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2991. Mr. MENENDEZ (for himself, Mr. ROCKEFELLER, Mr. BINGAMAN, and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2992. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2993. Mr. SCHUMER (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2994. Mr. SCHUMER (for himself, Mr. AKAKA, Mr. BROWN, Mr. LAUTENBERG, Mr. MERKLEY, Ms. CANTWELL, Mr. KERRY, Mr. LEAHY, Mr. MENENDEZ , and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2995. Mr. SCHUMER (for himself and Ms. MIKULSKI) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2996. Mr. KOHL (for himself, Mr. WYDEN, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2997. Ms. KLOBUCHAR (for herself, Mr. BROWN, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2998. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2999. Ms. SNOWE (for herself, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3000. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2953. Mr. UDALL of Colorado submited an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike line 11 on page 1204 and all that follows through line 16 on page 1206, insert the following:

(B) a local government agency, including municipal, county, and regional public health departments;

(C) a national network of community-based organizations;

(D) a State or local nonprofit organization;

(E) an Indian tribe; or

(F) a nonprofit hospital, clinic, or entity involved in health care delivery or health promotion; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to

engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(d) DIVERSITY.—In awarding grants under this section, the Secretary shall ensure, to the extent practicable, that such grants equitably serve racially, economically, and geographically diverse populations and include grants to rural local government agencies or organizations located in, and focused on serving, rural communities.

(e) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan shall focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity, and smoking cessation, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial, ethnic, and geographic disparities, including social determinants of health; and

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SA 2954. Mr. UDALL of Colorado (for himself and Mr. UDALL of New Mexico) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1265, between lines 8 and 9, insert the following:

SEC. 4307. PILOT PROGRAM TO REDUCE THE INCREASING PREVALENCE OF OVERWEIGHT/OBESITY AMONG CHILDREN FROM BIRTH THROUGH 5 YEARS OF AGE.

(a) FINDINGS.—Congress makes the following findings:

(1) Life-long food preferences, eating habits, and activity levels develop early in childhood.

(2) Preschool years are a critical time for determining whether or not an individual will develop obesity later in life.

(3) Aerobic fitness and healthy eating patterns support enhanced behavioral, emotional, and academic performance in school.

(4) Recent studies indicate that children who are overweight at age 5 are more likely to be more overweight at age 9.

(5) Obese preschool children already exhibit signs of cardiovascular disease and diabetes.

(6) According to a 2007 Centers for Disease Control and Prevention study, 12.4 percent of children in the United States ages 2 through 6 are obese.

(7) The 2001 National Household Education Survey found that 74 percent of children in the United States ages 3 through 6 are in some form of non-parental child care, and 56 percent are in center-based child care.

(8) According to a 2009 analysis of child care center licensing regulations, only 12 States have a policy prohibiting or limiting foods of low nutritional value in child care centers, only 8 States require vigorous or moderate physical activity, only one of which has a policy quantifying a required number of minutes of physical activity by day or week, and only 7 States quantify a maximum amount of time for media (television and electronic) each day or week.

(9) In July 2009, the Centers for Disease Control and Prevention released recommended community strategies and measures to prevent obesity in the United States that includes child care specific policy and environmental initiatives to achieve healthy eating and active living among children from birth to 5 years of age.

(10) In September 2009, The Institute of Medicine released findings supporting local governments' ability to play a crucial role in creating environments that make it easier for children to eat healthy diets and remain active.

(11) States should strive to adopt nutrition standards, practices, and policies for childcare centers that are consistent with the 2005 Dietary Guidelines for Americans.

(12) The Child and Adult Care Food Program is a Federal initiative that provides States with grants to provide children and adults in care settings with nutritious meals and snacks.

(13) Childcare centers should serve as settings where children adopt healthy eating habits, have opportunities for age appropriate physical activity, and set screen time limits.

(b) PURPOSES.—It is the purpose of this Act to—

(1) establish a 3-year pilot program in 5 States that will focus on reducing the increasing prevalence of overweight/obesity among children between birth and 5 years of age in child care settings;

(2) enhance the focus of child care centers serving the birth to 5 years of age population on children's healthy development through evidence-based or data-informed policies and practices to improve healthy eating, physical activity, and screen time limits; and

(3) identify emerging and expand existing evidence-based practices and understanding of healthy eating, physical activity, and screen time limits, as appropriate, as well as replicate curricula, interventions, practices, and policy changes that are most effective in promoting nutrition and physical activity among the birth to 5 years of age population in the child care setting.

(c) DEFINITIONS.—In this section:

(1) CHILD CARE CENTER.—The term ''child care center'' means a nonresidential facility that generally provides child care services for fewer than 24 hours per day per child, unless care in excess of 24 hours is due to the nature of the parents' work, and that is certified, registered, or licensed in the State in which it is located.

(2) EARLY LEARNING COUNCIL.—The term ''early learning council'' means an early childhood assembly that is established to advise governors, State legislators, or State agency administrators on how best to meet the needs of young children and their families specifically through improvement of programs and services.

(3) FAMILY CHILD CARE HOME.—The term ''family child care home'' means a private family home where home-based child care is provided for a portion of the day, unless care in excess of 24 hours is due to the nature of the parents' work, and that is certified, registered, or licensed in the State in which it is located.

(4) SCREEN TIME LIMITS.—The term ''screen time limits'' means policies or guidelines, such as those developed by the American Academy of Pediatrics, designed to reduce the daily amount of time that children spend watching or looking at digital monitors or displays, including television sets, computer monitors, or hand-held gaming devices.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) GRANTS.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award 3-year competitive grants to 5 State health departments (or other appropriate State agency administering the Child and Adult Care Food Program or other child care programs) to help reduce and prevent obesity among the birth to 5 year old population of the State in child care centers and family child care homes.

(2) USE OF FUNDS.—State grantees shall use amounts received under a grant under this subsection to—

(A) provide, or enter into contracts to provide, training (that meets the requirements of paragraph (3)) to the staff of national, State, or community-based organizations with networks of child care centers, or a consortium of childcare centers and family child care homes consisting of at least 10 child care centers or family child care homes, for the purpose of implementing evidence-based or data-informed healthy eating and physical activity policies and practices, including curricula and other interventions; and

(B) provide grants to child care centers and family child care homes, whose staff received the training described in subparagraph (A), to implement practice, curricula, and policy changes (that meet the requirements of paragraph (4)) that promote healthy eating and physical activity among the birth to 5 years of age population.

In determining who receives grant funds, a State shall consider, but not be limited to, child care centers and family child care homes that receive funds under the Child and Adult Care Food Program administered by the Department of Agriculture. Preference shall be given to those States that demonstrate collaboration between relevant State entities related to child care and health and with key stakeholders, such as State early learning councils and other community based organizations working with child care centers or family child care homes.

(3) TRAINING REQUIREMENTS.—

(A) IN GENERAL.—Training provided under paragraph (2) shall—

(i) include the provision of information concerning age-appropriate healthy eating and physical activity interventions and curricula for the birth to 5 years of age population in the State involved;

(ii) identify, improve upon, and expand nutrition and physical activity best practices targeted to the birth to 5 years of age population in the State involved and identify strategies for incorporating parental education and other parental involvement; and

(iii) provide instruction on how to appropriately model, direct, and encourage child care staff behavior to apply the best practices and strategies identified under clause (ii).

(B) TRAINING ENTITIES.—A grantee may conduct the training required under this subsection directly, or may provide such training through a contract with—

(i) an appropriate national, State, or community organization with relevant expertise;

(ii) a health care provider or professional organization with relevant expertise;

(iii) a university or research center that employs faculty with relevant expertise; or

(iv) any other entity determined appropriate by the State and approved by the Secretary.

(C) REQUIREMENT OF CONTRACT.—If a grantee elects to provide the training under this subsection through a contract, the grantee shall ensure that a consistent healthy eating and physical activity curriculum is being developed for all child care entities that provide care for 10 or more children throughout the State.

(4) PRACTICE, CURRICULA, AND POLICY CHANGES.—After training is provided as required under paragraph (3), a State grantee shall ensure that the organizations and consortium involved—

(A) implement, in child care settings, evidence-based or data-informed policy changes that promote healthy eating, physical activity, and appropriate screen time limits among the birth to 5 years of age population;

(B) utilize an evidence-based or data-informed healthy eating and physical activity curriculum in child care settings focusing on such birth to 5 age population;

(C) implement programs, activities, and procedures for incorporating parental education and involvement of parents in programs, including disseminating a written parental involvement policy, and coordinating and integrating parental involvement strategies under this section, to the extent feasible and appropriate, with parental involvement strategies under other programs, such as the Head Start program and the Early Head Start Program; and

(D) find innovative ways to remove barriers that exist to providing opportunities for healthy eating and physical activity.

All activities described in this paragraph shall be evidence-based or data-informed and be consistent with the curriculum presented through training activities described in paragraph (3).

(e) GRANTS FOR THE EVALUATION OF PILOT PROGRAMS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award competitive grants to Prevention Research Centers or universities to evaluate the programs carried out with grants under subsection (d), including baseline, process, and outcome measurements.

(f) COORDINATION.—

(1) INTERAGENCY COORDINATION.—To the extent practicable, the Secretary, acting through the Centers for Disease Control and Prevention, shall coordinate activities conducted under this section with activities undertaken by the National Prevention, Health Promotion and Public Health Council established under section 4001. Where possible, such coordination should—

(A) include the sharing of current and emerging best practices concerning healthy eating, physical activity, and screen time limits that have a population-level impact in promoting nutrition and physical activity in child care settings;

(B) promote the effective implementation and sustainability of such programs; and

(C) avoid unnecessary duplication of effort.

(2) PILOT COORDINATION.—The Director of the Centers for Disease Control and Prevention shall designate an individual (directly or through contract) to provide technical assistance to States and pilot centers in the development, implementation, and evaluation of activities and dissemination of information described in subparagraphs (A), (B), and (C) of paragraph (1).

(g) EVALUATION AND REPORTING.—

(1) TECHNICAL ASSISTANCE AND INFORMATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

(A) provide technical assistance to grantees and other entities providing training under a grant under this section; and

(B) disseminate to health departments and trainers under grants under this section information concerning evidence-based or data-informed approaches, including dissemination of existing toolkits, curricula, and existing or emerging best practices that can be expanded or improved upon through a program conducted under this section.

(2) EVALUATION REQUIREMENTS.—With respect to evaluations conducted under subsection (e), the Secretary, acting through the Director of the Center for Disease Control and Prevention, shall ensure that—

(A) evaluation metrics are consistent across all programs funded under this section;

(B) interim outcomes are measured by the number of centers that have implemented policy and environmental strategies that support use of curricula and practices supporting healthy eating, physical activity, and screen time limits;

(C) interim outcomes are measured, to the extent possible, by behavior changes in healthy eating, physical activity, and screen time; and

(D) upon completion of the program, the evaluation shall include an identification of best practices relating to behavior change and reductions in the increasing prevalence of overweight and obesity that could be replicated in other settings.

(3) DISSEMINATION OF INFORMATION.—Upon the conclusion of the programs carried out under this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall disseminate evidence, best practices, and lessons learned from grantees and shall submit to Congress a report concerning the evaluation of such programs, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Director for States and communities funded for nutrition, physical activity, and obesity prevention.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $7,500,000 for each of fiscal years 2011, 2012 and 2013.

SA 2955. Mr. UDALL of Colorado (for himself, Mrs. HAGAN, Ms. KLOBUCHAR, Mr. BEGICH, Mr. KAUFMAN, Mr. UDALL of New Mexico, Mr. KIRK, Mr. KOHL, Mr. FRANKEN, Mr. SPECTER, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

SEC. 5510. RURAL PHYSICIAN TRAINING GRANTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) after the part heading, by inserting the following:

"Subpart I—Medical Training Generally";

and

(2) by inserting at the end the following:

"Subpart II—Training in Underserved Communities

"SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program to make grants to eligible entities for the purposes of—

''(1) assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities;

''(2) providing rural-focused training and experience; and

''(3) increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

''(b) ELIGIBLE ENTITIES.—In order to be eligible to receive a grant under this section, an entity shall—

''(1) be a school of allopathic or osteopathic medicine accredited by a nationally recognized accrediting agency or association approved by the Secretary for this purpose, or any combination or consortium of such schools; and

''(2) submit an application to the Secretary at such time, in such form, and containing such information as the Secretary may require, including a certification that such entity—

''(A) will use amounts provided to the institution to—

''(i) establish and carry out a Rural Physician Training Program described in subsection (d);

''(ii) improve an existing rural-focused training program to meet the requirements described in subsection (d) and carry out such program; or

''(iii) expand and carry out an existing rural-focused training program that meets the requirements described in subsection (d); and

''(B) employs, or will employ within a timeframe sufficient to implement the Program (as described by a timetable and supporting documentation in the application of the eligible entity), faculty with experience or training in rural medicine or with experience in training rural physicians.

''(c) PRIORITY.—In awarding grant funds under this section, the Secretary shall give priority to eligible entities that—

''(1) demonstrate a record of successfully training students, as determined by the Secretary, who practice medicine in underserved rural communities;

''(2) demonstrate that an existing academic program of the eligible entity produces a high percentage, as determined by the Secretary, of graduates from such program who practice medicine in underserved rural communities;

''(3) demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise (such as dental, vision, or mental health services) in community health center training locations or other similar facilities; or

''(4) submit, as part of the application of the entity under subsection (b), a plan for the long-term tracking of where the graduates of such entity are practicing medicine.

''(d) USE OF FUNDS.—

''(1) ESTABLISHMENT.—An eligible entity receiving a grant under this section shall use the funds made available under such grant to—

''(A) establish and carry out a 'Rural Physician Training Program' (referred to in this section as the 'Program');

''(B) improve an existing rural-focused training program to meet the Program requirements described in this subsection and carry out such program; or

''(C) expand and carry out an existing rural-focused training program that meets the Program requirements described in this subsection.

''(2) STRUCTURE OF PROGRAM.—An eligible entity shall—

''(A) enroll no fewer than 10 students per class year into the Program; and

''(B) develop criteria for admission to the Program that gives priority to students—

''(i) who have originated from or lived for a period of 2 or more years in an underserved rural community; and

''(ii) who express a commitment to practice medicine in an underserved rural community.

''(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—

''(A) clinical rotations in underserved rural communities, and in specialties including family medicine, internal medicine, pediatrics, surgery, psychiatry, and emergency medicine;

''(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities, including in areas such as trauma, obstetrics, ultrasound, oral health, and behavioral health; and

''(C) any coursework or clinical experience that—

''(i) may be developed as a result of the Symposium described in subsection (f); or

''(ii) the Secretary finds appropriate.

''(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities, as well as assist all students of the Program in obtaining postgraduate residency training in such programs.

''(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in social, educational, and other group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.

''(e) ANNUAL REPORTING REQUIREMENT.—On an annual basis, an eligible entity receiving a grant under this section shall submit a report to the Secretary on—

''(1) the overall success of the Program established by the entity, based on criteria the Secretary determines appropriate;

''(2) the number of students participating in the Program;

''(3) the number of graduating students who participated in the Program;

''(4) the residency program selection of graduating students who participated in the Program;

''(5) the number of graduates who participated in the Program who are practicing in underserved rural communities not less than one year after completing residency training; and

''(6) the number of graduates who participated in the Program who are not practicing in underserved rural communities not less than one year after completing residency training.

''(f) RURAL TRAINING PROGRAM SYMPOSIUM.—

''(1) PURPOSES OF SYMPOSIUM.—To assist the Secretary in carrying out the Program and making grant determinations under this section, the Secretary shall convene a Rural Training Program Symposium (referred to in this section as the 'Symposium') to—

''(A) develop best practices that may be incorporated into consideration of applications under subsection (b); and

''(B) establish a network of allopathic and osteopathic medical schools that have developed or will develop rural training programs in accordance with subsection (d).

''(2) COMPOSITION.—The Symposium shall include—

''(A) representatives from eligible entities with existing rural training programs;

''(B) representatives from all eligible entities interested in developing the Program;

''(C) representatives from area health education centers;

''(D) representatives from the Health Resources and Services Administration; and

''(E) any other experts or individuals with experience in practicing medicine in underserved rural communities the Secretary determines appropriate.

''(g) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define 'underserved rural community' for purposes of this section.

''(h) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.

''(i) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

''(1) to carry out this section (other than subsection (f))—

''(A) $4,000,000 for fiscal year 2010;

''(B) $8,000,000 for fiscal year 2011;

''(C) $12,000,000 for fiscal year 2012;

''(D) $16,000,000 for fiscal year 2013; and

''(2) to carry out subsection (f), such sums as may be necessary.''.

SA 2956. Mr. UDALL of Colorado (for himself, Mr. HARKIN, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590 to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for the purposes; which was ordered to lie on the table; as follows:

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

Subtitle F—Physical Activity Guidelines and Foundation

PART I—PHYSICAL ACTIVITY GUIDELINES

SEC. 4501. ESTABLISHMENT OF PHYSICAL ACTIVITY GUIDELINES.

(a) REPORT.—

(1) IN GENERAL.—At least every 5 years, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall publish a report entitled ''Physical Activity Guidelines for Americans''. Each such report shall contain physical activity information and guidelines for the general public, and shall be promoted by each Federal agency in carrying out any Federal health program.

(2) BASIS OF GUIDELINES.—The information and guidelines contained in each report required under paragraph (1) shall be based on the preponderance of the scientific and medical knowledge which is current at the time the report is prepared.

(b) APPROVAL BY SECRETARY.—

(1) REVIEW.—Any Federal agency that proposes to issue any physical activity guidance for the general population or identified population subgroups shall submit the text of such guidance to the Secretary for a 60-day review period.

(2) BASIS OF REVIEW.—

(A) IN GENERAL.—During the 60-day review period established in paragraph (1), the Secretary shall review and approve or disapprove such guidance to assure that the guidance either is consistent with the ''Physical Activity Guidelines for Americans'' or that the guidance is based on medical or new scientific knowledge which is determined to be valid by the Secretary. If after such 60-day review period the Secretary has not notified the proposing agency that such guidance has been disapproved, then such guidance may be issued by the agency. If the Secretary disapproves such guidance, it shall be returned to the agency. If the Secretary finds that such guidance is inconsistent with the ''Physical Activity Guidelines for Americans'' and so notifies the proposing agency, such agency shall follow the procedures set forth in this subsection before disseminating such proposal to the public in final form. If after such 60-day period, the Secretary disapproves such guidance as inconsistent with the ''Physical Activity Guidelines for Americans'' the proposing agency shall—

(i) publish a notice in the Federal Register of the availability of the full text of the proposal and the preamble of such proposal which shall explain the basis and purpose for the proposed physical activity guidance;

(ii) provide in such notice for a public comment period of 30 days; and

(iii) make available for public inspection and copying during normal business hours any comment received by the agency during such comment period.

(B) REVIEW OF COMMENTS.—After review of comments received during the comment period, the Secretary may approve for dissemination by the proposing agency a final version of such physical activity guidance along with an explanation of the basis and purpose for the final guidance which addresses significant and substantive comments as determined by the proposing agency.

(C) ANNOUNCEMENT.—Any such final physical activity guidance to be disseminated under subparagraph (B) shall be announced in a notice published in the Federal Register, before public dissemination along with an address where copies may be obtained.

(D) NOTIFICATION OF DISAPPROVAL.—If after the 30-day period for comment as provided under subparagraph (A)(ii), the Secretary disapproves a proposed physical activity guidance, the Secretary shall notify the Federal agency submitting such guidance of such disapproval, and such guidance may not be issued, except as provided in subparagraph (E).

(E) REVIEW OF DISAPPROVAL.—If a proposed physical activity guidance is disapproved by the Secretary under subparagraph (D), the Federal agency proposing such guidance

may, within 15 days after receiving notification of such disapproval under subparagraph (D), request the Secretary to review such disapproval. Within 15 days after receiving a request for such a review, the Secretary shall conduct such review. If, pursuant to such review, the Secretary approves such proposed physical activity guidance, such guidance may be issued by the Federal agency.

(3) DEFINITIONS.—In this subsection:

(A) The term ''physical activity guidance for the general population'' does not include any rule or regulation issued by a Federal agency.

(B) The term ''identified population subgroups'' shall include, but not be limited to, groups based on factors such as age, sex, race, or physical disability.

(c) EXISTING AUTHORITY NOT AFFECTED.—This section does not place any limitations on—

(1) the conduct or support of any scientific or medical research by any Federal agency; or

(2) the presentation of any scientific or medical findings or the exchange or review of scientific or medical information by any Federal agency.

PART II—NATIONAL FOUNDATION ON PHYSICAL FITNESS AND SPORTS

SEC. 4511. ESTABLISHMENT AND PURPOSE OF FOUNDATION.

(a) ESTABLISHMENT.—There is established the National Foundation on Physical Fitness and Sports (hereinafter in this part referred to as the ''Foundation''). The Foundation is a charitable and nonprofit corporation and is not an agency or establishment of the United States.

(b) PURPOSES.—The purposes of the Foundation are—

(1) in conjunction with the President's Council on Physical Fitness and Sports, to develop a list and description of programs, events and other activities which would further the goals outlined in Executive Order 12345 and with respect to which combined private and governmental efforts would be beneficial; and

(2) to encourage and promote the participation by private organizations in the activities referred to in subsection (b)(1) and to encourage and promote private gifts of money and other property to support those activities.

(c) DISPOSITION OF MONEY AND PROPERTY.—At least annually the Foundation shall transfer, after the deduction of the administrative expenses of the Foundation, the balance of any contributions received for the activities referred to in subsection (b), to the United States Public Health Service Gift Fund pursuant to section 2701 of the Public Health Service Act (42 U.S.C. 300aaa) for expenditure pursuant to the provisions of that section and consistent with the purposes for which the funds were donated.

SEC. 4512. BOARD OF DIRECTORS OF THE FOUNDATION.

(a) ESTABLISHMENT AND MEMBERSHIP.—The Foundation shall have a governing Board of Directors (hereinafter referred to in this part as the ''Board''), which shall consist of 9 members each of whom shall be a United States citizen and—

(1) 3 of whom must be knowledgeable or experienced in one or more fields directly connected with physical fitness, sports, or the relationship between health status and physical exercise; and

(2) 6 of whom must be leaders in the private sector with a strong interest in physical fitness, sports, or the relationship between health status and physical exercise.

The membership of the Board, to the extent practicable, shall represent diverse professional specialties relating to the achievement of physical fitness through regular participation in programs of exercise, sports, and similar activities. The Assistant Secretary for Health, the Executive Director of the President's Council on Physical Fitness and Sports, the Director for the National Center for Chronic Disease Prevention and Health Promotion, the Director of the National Heart, Lung, and Blood Institute, and the Director for the Centers for Disease Control and Prevention shall be ex officio, nonvoting members of the Board. Appointment to the Board or its staff shall not constitute employment by, or the holding of an office of, the United States for the purposes of any Federal employment or other law.

(b) APPOINTMENTS.—Within 90 days from the date of enactment of this Act, the members of the Board will be appointed. Three members of the Board will be appointed by the Secretary (hereinafter referred to in this part as the ''Secretary''), 2 by the majority leader of the Senate, 1 by the minority leader of the Senate, 2 by the Speaker of the House of Representatives, 1 by the minority leader of the House of Representatives.

(c) TERMS.—The members of the Board shall serve for a term of 6 years. A vacancy on the Board shall be filled within 60 days of the vacancy in the same manner in which the original appointment was made and shall be for the balance of the term of the individual who was replaced. No individual may serve more than 2 consecutive terms as a member.

(d) CHAIRMAN.—The Chairman shall be elected by the Board from its members for a 2-year term and will not be limited in terms or service.

(e) QUORUM.—A majority of the current membership of the Board shall constitute a quorum for the transaction of business.

(f) MEETINGS.—The Board shall meet at the call of the Chairman at least once a year. If a member misses 3 consecutive regularly scheduled meetings, that member may be removed from the Board and the vacancy filled in accordance with subsection (c).

(g) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may be reimbursed for the actual and necessary traveling and subsistence expenses incurred by them in the performance of the duties of the Foundation, subject to the same limitations on reimbursement that are imposed upon employees of Federal agencies.

(h) LIMITATIONS.—The following limitations apply with respect to the appointment of officers and employees of the Foundation:

(1) Officers and employees may not be appointed until the Foundation has sufficient funds to pay them for their service. No individual so appointed may receive pay in excess of the annual rate of basic pay in effect for Executive Level V in the Federal service.

(2) The first officer or employee appointed by the Board shall be the Secretary of the Board who shall serve, at the direction of the Board, as its chief operating officer and shall be knowledgeable and experienced in matters relating to physical fitness and sports.

(3) No Public Health Service employee nor the spouse or dependent relative of such an employee may serve as an officer or member of the Board of Directors or as an employee of the Foundation.

(4) Any individual who is an officer, employee, or member of the Board of the Foundation may not (in accordance with the policies developed under subsection (i)) personally or substantially participate in the consideration or determination by the Foundation of any matter that would directly or predictably affect any financial interest of the individual or a relative (as such term is defined in section 109(16) of the Ethics in Government Act, 1978) of the individual, of any business organization, or other entity, or of which the individual is an officer or employee, is negotiating for employment, or in which the individual has any other financial interest.

(i) GENERAL POWERS.—The Board may complete the organization of the Foundation by—

(1) appointing officers and employees;

(2) adopting a constitution and bylaws consistent with the purposes of the Foundation and the provision of this part; and

(3) undertaking such other acts as may be necessary to carry out the provisions of this part.

In establishing bylaws under this subsection, the Board shall provide for policies with regard to financial conflicts of interest and ethical standards for the acceptance, solicitation and disposition of donations and grants to the Foundation.

SEC. 4513. RIGHTS AND OBLIGATIONS OF THE FOUNDATION.

(a) IN GENERAL.—The Foundation—

(1) shall have perpetual succession;

(2) may conduct business throughout the several States, territories, and possessions of the United States;

(3) shall have its principal offices in or near the District of Columbia; and

(4) shall at all times maintain a designated agent authorized to accept service of process for the Foundation.

The serving of notice to, or service of process upon, the agent required under paragraph (4), or mailed to the business address of such agent, shall be deemed as service upon or notice to the Foundation.

(b) SEAL.—The Foundation shall have an official seal selected by the Board which shall be judicially noticed.

(c) POWERS.—To carry out its purposes under section 4511, and subject to the specific provisions thereof, the Foundation shall have the usual powers of a corporation acting as a trustee in the District of Columbia, including the power—

(1) except as otherwise provided herein, to accept, receive, solicit, hold, administer and use any gift, devise, or bequest, either absolutely or in trust, of real or personal property or any income therefrom or other interest therein;

(2) to acquire by purchase or exchange any real or personal property or interest therein;

(3) unless otherwise required by the instrument of transfer, to sell, donate, lease, invest, reinvest, retain or otherwise dispose of any property or income therefrom;

(4) to sue and be sued, and complain and defend itself in any court of competent jurisdiction, except for gross negligence;

(5) to enter into contracts or other arrangements with public agencies and private organizations and persons and to make such payments as may be necessary to carry out its functions; and

(6) to do any and all acts necessary and proper to carry out the purposes of the Foundation.

For purposes of this part, an interest in real property shall be treated as including easements or other rights for preservation, conservation, protection, or enhancement by and for the public of natural, scenic, historic, scientific, educational inspirational or recreational resources. A gift, devise, or bequest may be accepted by the Foundation even though it is encumbered, restricted, or subject to beneficial interests of private persons if any current or future interest therein is for the benefit of the Foundation.

SEC. 4514. PROTECTION AND USES OF TRADEMARKS AND TRADE NAMES.

(a) PROTECTION.—Without the consent of the Foundation in conjunction with the President's Council on Physical Fitness and Sports, any person who uses for the purpose

of trade, uses to induce the sale of any goods or services, or uses to promote any theatrical exhibition, athletic performance or competition—

(1) the official seal of the President's Council on Physical Fitness and Sports consisting of the eagle holding an olive branch and arrows with shield breast encircled by name ''President's Council on Physical Fitness and Sports'' and consisting, depending upon placement, of diagonal stripes;

(2) the official seal of the Foundation; or

(3) any trademark, trade name, sign, symbol, or insignia falsely representing association with or authorization by the President's Council on Physical Fitness and Sports or the Foundation;

shall be subject in a civil action by the Foundation for the remedies provided in the Act of July 9, 1946 (60 Stat. 427; popularly known as the Trademark Act of 1946).

(b) USES.—The Foundation, in conjunction with the President's Council on Physical Fitness and Sports, may authorize contributors and suppliers of goods or services to use the trade name or the President's Council on Physical Fitness and Sports and the Foundation as well as any trademark, seal, symbol, insignia, or emblem of the President's Council on Physical Fitness and Sports or the Foundation in advertising that the contributors, goods, or services when donated, supplied, or furnished to or for the use of, or approved, selected, or used by the President's Council on Physical Fitness and Sports or the Foundation.

SEC. 4515. VOLUNTEER STATUS.

The Foundation may accept, without regard to the civil service classification laws, rules, or regulations, the services of volunteers in the performance of the functions authorized herein, in the manner provided for under section 7(c) of the Fish and Wildlife Act of 1956 (16 U.S.C. 742f(c)).

SEC. 4516. AUDIT, REPORT REQUIREMENTS, AND PETITION OF ATTORNEY GENERAL FOR EQUITABLE RELIEF.

(a) AUDITS.—For purposes of the Act entitled ''An Act for audit of accounts of private corporations established under Federal law'', approved August 30, 1964 (Public Law 88–504, 36 U.S.C. 1101–1103), the Foundation shall be treated as a private corporation under Federal law. The Inspector General of the Department of Health and Human Services and the Comptroller General of the United States shall have access to the financial and other records of the Foundation, upon reasonable notice.

(b) REPORT.—The Foundation shall, as soon as practicable after the end of each fiscal year, transmit to the Secretary of Health and Human Services and to Congress a report of its proceedings and activities during such year, including a full and complete statement of its receipts, expenditures, and investments.

(c) RELIEF WITH RESPECT TO CERTAIN FOUNDATION ACTS OR FAILURE TO ACT.—If the Foundation—

(1) engages in, or threatens to engage in, any act, practice or policy that is inconsistent with its purposes set forth in section 4511(b); or

(2) refuses, fails, or neglects to discharge its obligations under this part, or threaten to do so;

the Attorney General of the United States may petition in the United States District Court for the District of Columbia for such equitable relief as may be necessary or appropriate.

SEC. 4517. AUTHORIZATION OF APPROPRIATIONS.

For fiscal year 2010, there are authorized to be appropriated such sums as may be necessary, to be made available to the Foundation for organizational costs.

SA 2957. Mr. BENNET (for himself and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 4101, insert the following:

(c) AMENDMENTS TO SCHOOL-BASED HEALTH CENTERS PROGRAM.—Section 399Z-1 of the Public Health Service Act, as added by subsection (b), is amended—

(1) in subsection (f)(1)(A)(iii), by inserting '', including programs to promote healthy, active lifestyles and wellness for students'' after ''programs'';

(2) by redesignating subsection (l) as subsection (m); and

(3) by inserting after subsection (k) the following:

''(l) REGULATIONS REGARDING REIMBURSEMENT FOR HEALTH SERVICES.—The Secretary shall issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including reimbursement under any insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act).''.

SA 2958. Mr. BENNET submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII, insert the following:

Subtitle C—Rural Health Access and Improvement

SEC. 7201. GRANTS TO PROMOTE HOSPITAL HEALTH INFORMATION TECHNOLOGY.

Section 3013 of the Public Health Service Act (42 U.S.C. 300jj–33) is amended by adding at the end the following:

''(j) PRIORITY.—In awarding a grant under this section, the Secretary shall give priority to qualified State-designated entities that are critical access hospitals, as defined in section 1861(mm) of the Social Security Act.''.

SEC. 7202. EXPANDED PARTICIPATION IN SECTION 340B PROGRAM.

Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), as amended by section 7101(a), is further amended by adding at the end the following:

''(P) An entity that is a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act.''.

SEC. 7203. GAO STUDY AND REPORT ON DISPENSING FEES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of the cost in each State of dispensing prescription drugs under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), which shall consider—

(1) any reasonable costs associated with pharmacists—

(A) checking for information regarding Medicaid coverage of individuals; and

(B) performing necessary clinical review and quality assurance activities, such as—

(i) activities to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care among physicians, pharmacists, and patients;

(ii) activities associated with specific drugs or groups of drugs, including potential and actual severe adverse reactions to drugs, including education on therapeutic appropriateness, over-utilization and under-utilization of drugs, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse; and

(iii) any other clinical review and quality assurance activities required under Federal or State law;

(2) the costs incurred by a pharmacy that are associated with—

(A) the measurement or mixing of a drug covered by Medicaid;

(B) filling the container for such a drug;

(C) physically transferring the prescription to the patient, including any costs of delivering the medication to the home of such patient;

(D) special packaging of drugs;

(E) overhead costs of the pharmacy, or the section of the facility that is devoted to a pharmacy, and maintenance of the pharmacy or section of the facility (including the equipment necessary to operate such pharmacy or such section and the salaries of pharmacists and other pharmacy workers);

(F) geographic factors that impact operational costs;

(G) compounding such prescription if necessary; and

(H) uncollectability of Medicaid prescription copayments;

(3) the variation in costs described in paragraph (2) based on—

(A) whether a product dispensed is a rural or urban pharmacy;

(B) whether the product dispensed is a specialty pharmacy product; and

(C) whether the pharmacy is located in, or contracts with, a long-term care facility; and

(4) the increase in dispensing fees, including the costs described in paragraphs (1), (2), and (3), that would be sufficient to create an incentive for a pharmacist to promote the use of generic medications.

(b) REPORT.—Not later than December 1, 2010, the Comptroller General of the United States shall submit to the Secretary of Health and Human Services and to each State a report describing the study conducted under subsection (a). The report shall include—

(1) the average cost in each State of dispensing a prescription drug under Medicaid;

(2) the findings of the study conducted under subsection (a) with respect to—

(A) the variation in costs studied under subparagraphs (A) and (B) of paragraph (3) of such subsection; and

(B) the increase in dispensing fees described in paragraph (4) of such subsection.

(c) USE OF STUDY.—Each State shall use the report described in subsection (b) to assess the adequacy of Medicaid pharmacy dispensing fees. The Secretary of Health and Human Services shall use such report to approve State plan amendments for States that submit such amendments for the purposes of increasing Medicaid pharmacy dispensing fees.

SEC. 7204. STATE OFFICES OF RURAL HEALTH.

Section 338J of the Public Health Service Act (42 U.S.C. 254r) is amended by striking subsection (k).

SA 2959. Mr. LEAHY (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 4403. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 233(o)(1)) is amended by inserting after ''to an individual'' the following: '', or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic,''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SA 2960. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3115. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDICARE DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.

(a) IN GENERAL.—Section 1861(qq) of the Social Security Act (42 U.S.C. 1395x(qq)) is amended—

(1) in paragraph (1), by inserting ''or by a certified diabetes educator (as defined in paragraph (3))'' after ''paragraph (2)(B)''; and

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

''(3) For purposes of paragraph (1), the term 'certified diabetes educator' means an individual who—

''(A) is licensed or registered by the State in which the services are performed as a health care professional;

''(B) specializes in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual's diabetic condition; and

''(C) is certified as a diabetes educator by a recognized certifying body (as defined in paragraph (4)).

''(4)(A) For purposes of paragraph (3)(C), the term 'recognized certifying body' means—

''(i) the National Certification Board for Diabetes Educators, or

''(ii) a certifying body for diabetes educators, which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary, if the Secretary determines such Board or body, respectively, meets the requirement of subparagraph (B).

''(B) The National Certification Board for Diabetes Educators or a certifying body for diabetes educators meets the requirement of this subparagraph, with respect to the certification of an individual, if the Board or body, respectively, is incorporated and registered to do business in the United States and requires as a condition of such certification each of the following:

''(i) The individual has a qualifying credential in a specified health care profession.

''(ii) The individual has professional practice experience in diabetes self-management training that includes a minimum number of hours and years of experience in such training.

''(iii) The individual has successfully completed a national certification examination offered by such entity.

''(iv) The individual periodically renews certification status following initial certification.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to diabetes outpatient self-management training services furnished on or after the first day of the first calendar year that is at least 6 months after the date of the enactment of this Act.

SA 2961. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1925, between lines 14 and 15, insert the following:

Subtitle C—Provisions Relating to Generic Drugs

SEC. 7201. LABELING CHANGES.

Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following:

''(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection differs from the listed drug due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502 if—

''(i) the application is otherwise eligible for approval under this subsection but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration;

''(ii) the labeling revision described under clause (i) does not include a change to the 'Warnings' section of the labeling;

''(iii) the sponsor of the application under this subsection agrees to submit revised labeling of the drug that is the subject of such application not later than 60 days after the notification of any changes to such labeling required by the Secretary; and

''(iv) such application otherwise meets the applicable requirements for approval under this subsection.

''(B) If, after a labeling revision described in subparagraph (A)(i), the Secretary determines that the continued presence in interstate commerce of the labeling of the listed drug (as in effect before the revision described in subparagraph (A)(i)) adversely impacts the safe use of the drug, no application under this subsection shall be eligible for approval with such labeling.''.

SA 2962. Mr. NELSON of Nebraska (for himself, Mr. HATCH, Mr. CASEY, Mr. BROWNBACK, Mr. THUNE, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. VITTER, Mr. BARRASSO, Mr. WICKER, Mr. BOND, Mr. BENNETT, and Mr. INHOFE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Beginning on page 116, strike line 15 and all that follows through line 15 on page 123, and insert the following:

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), nothing in this Act (or any amendment made by this Act) shall be construed to require any health plan to provide coverage of abortion services or to allow the Secretary or any other person or entity implementing this Act (or amendment) to require coverage of such services.

(2) COMMUNITY HEALTH INSURANCE OPTION.—The Secretary may not provide coverage of abortion services in the community health insurance option established under section 1323, except in the case where use of funds authorized or appropriated by this Act is permitted for such services under subsection (b)(1).

(3) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—No Exchange participating health benefits plan may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(b) LIMITATION ON ABORTION FUNDING.—

(1) IN GENERAL.—No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

(2) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall be construed as prohibiting any non-Federal entity (including an individual or a State or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act; and

(B) such coverage or plan is not purchased using—

(i) individual premium payments required for a qualified health plan offered through the Exchange towards which a credit is applied under section 36B of the Internal Revenue Code of 1986; or

(ii) other non-Federal funds required to receive a Federal payment, including a State's or locality's contribution of Medicaid matching funds.

(3) OPTION TO OFFER SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall restrict any non-Federal health insurance issuer offering a qualified health plan from offering separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act;

(B) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and

(C) any such non-Federal health insurance issuer that offers a qualified health plan through the Exchange that includes coverage for abortions for which funding is prohibited under this subsection also offers a qualified health plan through the Exchange that is identical in every respect except that it does not cover abortions for which funding is prohibited under this subsection.

SA 2963. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 90___. OPT-OUT OF TAXES AND FEES IMPOSED ON STATES AND INDIVIDUALS.

(a) IN GENERAL.—An individual or State may elect to opt out of any fee or tax imposed or increased under this Act or any amendment made by this Act, including the application of—

(1) the amendments made by section 9003 (relating to distributions for medicine qualified only if for prescribed drug or insulin), and

(2) the amendments made by section 9013 (relating to the modification of itemized deduction for medical expenses).

(b) PROCESS FOR ELECTION; NOTIFICATION OF OPT-OUT.—

(1) IN GENERAL.—Any election under subsection (a) shall be made by filing a statement (on line, by mail, or in such other manner as specified by the appropriate Secretary)—

(A) in the case of any tax provision, with the Secretary of the Treasury, and

(B) in the case of any other provision, with the Secretary of Health and Human Services. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall establish a form that may be used for making an election under subsection (a) and shall make such form available on the Internet.

(2) NOTIFICATION.—

(A) IN GENERAL.—Not later than 1 month after the date of the enactment of this Act, the Secretary of the Treasury, together with the Secretary of Health and Human Services, shall mail a notice to each individual who may make an election under subsection (a).

(B) CONTENT.—The notification under subparagraph (A) shall—

(i) state that this Act will create government-run health care exchanges and program that will be paid for in part with higher taxes and other fees, and

(ii) a form that can be used for opting out of such fees and taxes.

(3) REVOCATION.—An individual may revoke an election make under subsection (a) at any time in a manner similar to the manner in which the election is made under paragraph (1).

(c) RESPONSIBILITY REQUIREMENTS TREATED AS TAX PROVISIONS.—For purposes of this section, amounts imposed under sections 5000A and 4980H of the Internal Revenue Code of 1986, as added by this Act, shall be treated as taxes.

SA 2964. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 17, strike line 11 through line 14.

On page 396, between lines 8 and 9, insert the following:

SEC. 1563. ENSURING THAT GOVERNMENT HEALTH CARE RATIONING DOES NOT HARM, INJURE, OR DENY MEDICALLY NECESSARY CARE.

Notwithstanding any other provision of law—

(1) no individual may be denied health care based on age or life expectancy by any Federal health program, the community health insurance option established under section 1323, or any Exchange established under this Act; and

(2) no entity of the Federal Government may develop Quality-Adjusted Life Year measures or other similarly designed government formulas for limiting access to treatment.

Strike section 3403.

Strike section 4105.

On page 1680, between lines 20 and 21, insert the following:

''(2) PROHIBITION.—The findings of the Institute are prohibited from being used by any government entity for payment, coverage, or treatment decisions. Nothing in the preceding sentence shall limit a physician or other health care provider from using Institute reports and recommendations when making decisions about the best treatment for an individual patient in an individual circumstance.''.

At the end of subtitle G of title I, add the following:

SEC. 15___. IDENTIFICATION OF FEDERAL GOVERNMENT HEALTH CARE RATIONING.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct, and submit to Congress a report describing the results of, a study that compares, with regard to the programs described in subsection (b)—

(1) any restrictions or limitations regarding access to health care providers (including the percentage of health care providers willing or permitted to care for patients insured by each program);

(2) any restrictions, denials, or rationing relating to the provision of health care, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies;

(3) average wait times to see a primary care doctor;

(4) average wait times for medically necessary surgeries and medical procedures; and

(5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) PROGRAMS.—The programs referred to in subsection (a) are—

(1) Medicare;

(2) Medicaid;

(3) the Indian Health Service;

(4) the Department of Veterans Affairs; and

(5) the Federal Employee Health Benefits Program.

SA 2965. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After title IX, insert the following:

TITLE X—CERTIFICATION OF FINANCIAL SUSTAINABILITY AND FISCAL SOLVENCY

SEC. 10001. FINANCIAL SUSTAINABILITY AND FISCAL SOLVENCY REQUIREMENT.

Notwithstanding any other provision of law, the provisions of this Act (and the amendments made by this Act), including any health insurance programs created, run, or expanded by the government through this Act (or the amendments made by this Act), shall not take effect unless the actuary of the Department of Health and Human Services and the actuary of the Social Security Administration each independently certify, in testimony before Congress and in an official report to Congress, that, as of January 1, 2009, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) are financially sustainable and fiscally solvent through January 1, 2029.

SA 2966. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 621, strike line 10 and all that follows through page 1134, line 3, and insert the following:

TITLE III—REDUCING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

SEC. 3001. PREVENTION AND DETECTION OF WASTE, FRAUD, AND ABUSE WITHIN THE MEDICARE AND MEDICAID PROGRAMS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall develop and implement innovative technologies, systems, and procedures (as described under subsection (b)) to reduce waste, fraud, and abuse under the Medicare and Medicaid programs and ensure that amounts attributed to waste, fraud, and abuse constitute an amount not greater than 5 percent of all funds expended under the Medicare program.

(b) PREVENTION AND DETECTION MEASURES.—For purposes of subsection (a), the technologies, systems, and procedures to be developed and implemented by the Secretary shall include the following:

(1) Improving the Medicare beneficiary identifier (MBI) used to identify beneficiaries under the Medicare program to—

(A) ensure that the social security account numbers assigned to such beneficiaries are not used;

(B) provide such beneficiaries with machine-readable identification cards that employ a unique patient number; and

(C) establish a process for changing the MBI for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(2) Comprehensive real-time data matching across Federal agencies (similar to measures employed by the credit card industry) that is able to determine—

(A) whether a beneficiary under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible for benefits under such programs; and

(B) whether a provider of services or a supplier under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such programs.

(3) Imposition of direct financial penalties to facilities receiving funds under the Medicare or Medicaid programs that employ any physician, executive, or administrator that has been convicted of an offense involving fraud relating to the Medicare or Medicaid programs or reached a settlement relating to such an offense with the Federal Government or any State government.

(4) Use of procedures and technology (including front-end, pre-payment technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under the Medicare program to identify and investigate unusual billing or order practices that could indicate fraud or abuse.

(c) INVESTIGATION.—The Secretary shall, in the case where a provider of services or a supplier under the Medicare or Medicaid programs submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information obtained pursuant to subsection (b), is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, refer the matter to the Inspector General of the Department of Health and Human Services for investigation not later than 14 days after the Secretary has made such a determination.

(d) DEFINITIONS.—In this title:

(1) MEDICAID.—The term ''Medicaid'' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) MEDICARE.—The term ''Medicare'' means the program for medical assistance established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 3002. REINVESTMENT OF SAVINGS INTO MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary under section 3001 shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (42 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 3003. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) IN GENERAL.—The Secretary shall establish a demonstration project that uses practicing health care professionals to conduct undercover investigations of other health care professionals.

(b) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary, in coordination with the Office of the Inspector General of the Department of Health and Human Services (referred to in this section as the ''Inspector General''), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that receive reimbursements through any Federal public health care program.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or

(B) any level of Medicaid fraud.

(c) ELIGIBILITY.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) ACTIVITIES.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) FOLLOW-UP BY THE INSPECTOR GENERAL.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) LIMITATION.—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) FUNDING.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.

SA 2967. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 124, line 1 insert ''OTHER'' before ''FEDERAL''.

On page 124, line 4, insert ''other'' before ''Federal''.

On page 124, between lines 22 and 23, insert the following:

SEC. 1304. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

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

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

(2) require any health care entity that is established or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination;

on the basis that such health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

(c) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

SA 2968. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike subtitle D of title IV and insert the following:

Subtitle D—Prohibition on Comparative Effectiveness Research for the Purpose of Determining Cost and Coverage Decisions

SEC. 4301. PROHIBITION ON COMPARATIVE EFFECTIVENESS RESEARCH FOR THE PURPOSE OF DETERMINING COST AND COVERAGE DECISIONS.

Reports and recommendations from the Patient-Centered Outcomes Research Institute, established under section 1181 of the Social Security Act (as added by section 6301), are prohibited from being used by any government entity for payment, coverage, or treatment decisions based on cost. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of such Institute when making decisions about the best treatment for an individual patient in an individual circumstance.

SA 2969. Mr. COBURN (for himself, Mr. GRASSLEY, Mr. BURR, Mr. VITTER, Mrs. MCCASKILL, and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr.

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

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

(D) REQUIREMENT OF MEMBERS OF CONGRESS AND OTHERS TO ENROLL IN THE PUBLIC OPTION.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, all Federal officers shall be enrolled in the community health insurance option when established by the Secretary.

(ii) INELIGIBLE FOR FEHBP.—Effective on the date on which the community health insurance option is established by the Secretary, no Federal officer shall be eligible to participate in a health benefits plan under chapter 89 of title 5, United States Code.

(iii) EMPLOYER CONTRIBUTION.—

(I) IN GENERAL.—The appropriate disbursing officer for each Federal officer shall pay the amount determined under subclause (II) to—

(aa) the appropriate community health insurance option; or

(bb) in the case of a Federal officer who resides in a State which opts out of providing a community health insurance option and is enrolled in a plan offered through an Exchange, the appropriate Exchange.

(II) AMOUNT OF EMPLOYER CONTRIBUTION.—The Director of the Office of Personnel Management shall determine the amount of the employer contribution for each Federal officer. The amount shall be equal to the employer contribution for the health benefits plan under chapter 89 of title 5, United States Code, with the greatest number of enrollees, except that the contribution shall be actuarially adjusted for age.

(iv) DEFINITIONS.—In this subparagraph:

(I) COMMUNITY HEALTH INSURANCE OPTION.—The term ''community health insurance option'' means the health insurance established by the Secretary under section 1323.

(II) CONGRESSIONAL EMPLOYEE.—The term ''congressional employee'' means an employee of—

(aa) a committee of the Senate or House of Representatives;

(bb) the office of a Member of Congress;

(cc) the Majority Leader of the Senate;

(dd) the Minority Leader of the Senate;

(ee) the Speaker of the House of Representatives; or

(ff) the Minority Leader of the House of Representatives;

(III) FEDERAL OFFICER.—The term ''Federal officer'' means—

(aa) a Member of Congress;

(bb) the President;

(cc) the Vice President;

(dd) a political appointee; and

(ee) a congressional employee.

(IV) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

(V) POLITICAL APPOINTEE.—The term ''political appointee'' means any individual who—

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

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

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

SA 2970. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___PULMONARY HYPERTENSION RESEARCH AND EDUCATION

SEC. _01. SHORT TITLE.

This title may be cited as the ''Tom Lantos Pulmonary Hypertension Research and Education Act of 2009''.

Subtitle A—Research on Pulmonary Hypertension

SEC. _11. EXPANSION AND INTENSIFICATION OF ACTIVITIES.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) the Secretary of Health and Human Services (in this Act referred to as the ''Secretary''), acting through the Director of the National Institutes of Health and the Director of the National Heart, Lung, and Blood Institute (in this title referred to as the ''Institute''), should continue aggressive work on pulmonary hypertension;

(2) as part of such work, the Director of the Institute should continue research to expand the understanding of the causes of, and to find a cure for, pulmonary hypertension; and

(3) activities under paragraph (1) may include conducting and supporting—

(A) basic research concerning the etiology and causes of pulmonary hypertension;

(B) basic research on the relationship between scleroderma, sickle cell anemia (and other conditions identified by the Director of the Institute that can lead to a secondary diagnosis of pulmonary hypertension), and pulmonary hypertension;

(C) clinical research for the development and evaluation of new treatments for pulmonary hypertension, including the establishment of a ''Pulmonary Hypertension Clinical Research Network'';

(D) support for the training of new clinicians and investigators with expertise in the pulmonary hypertension; and

(E) information and education programs for the general public.

(b) BIENNIAL REPORTS.—As part of the biennial report made under section 403 of the Public Health Service Act (42 U.S.C. 283), the Secretary shall include information on the status of pulmonary hypertension research at the National Institutes of Health.

Subtitle B—Increasing Awareness of Pulmonary Hypertension

SEC. _21. PROMOTING PUBLIC AWARENESS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out an educational campaign to increase public awareness of pulmonary hypertension. Print, video, and Web-based materials distributed under this program may include—

(1) basic information on pulmonary hypertension and its symptoms; and

(2) information on—

(A) the incidence and prevalence of pulmonary hypertension;

(B) diseases and conditions that can lead to pulmonary hypertension as a secondary diagnosis;

(C) the importance of early diagnosis; and

(D) the availability, as medically appropriate, of a range of treatment options and pulmonary hypertension.

(b) DISSEMINATION OF INFORMATION.—The Secretary is encouraged to disseminate information under subsection (a) through a cooperative agreement with a national nonprofit entity with expertise in pulmonary hypertension.

(c) REPORT TO CONGRESS.—Not later than September 30, 2010, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Appropriations of the House of Representatives and the Senate on the status of activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $2,500,000 for each of fiscal years 2010, 2011, and 2012.

SEC. _22. PROMOTING AWARENESS AMONG HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention, shall carry out an educational campaign to increase awareness of pulmonary hypertension among health care providers. Print, video, and Web-based materials distributed under this program may include information on—

(1) the symptoms of pulmonary hypertension;

(2) the importance of early diagnosis;

(3) current diagnostic criteria; and

(4) Food and Drug Administration-approved therapies for the disease.

(b) TARGETED HEALTH CARE PROVIDERS.—Health care providers targeted through the campaign under subsection (a) shall include, but not be limited to, cardiologists, pulmonologists, rheumatologists, primary care physicians, pediatricians, and nurse practitioners.

(c) DISSEMINATION OF INFORMATION.—The Secretary is encouraged to disseminate information under subsection (a) through a cooperative agreement with a national nonprofit entity with expertise in pulmonary hypertension.

(d) REPORT TO CONGRESS.—Not later than September 30, 2010, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Appropriations of the House of Representatives and the Senate on the status of activities under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $2,500,000 for each of fiscal years 2010, 2011, and 2012.

SA 2971. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other

purposes; which was ordered to lie on the table; as follows:

On page 731, strike line 9 and all that follows through line 16 and insert the following:

clude a teaching hospital or medical school, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

''(xix) Determining the efficacy of methods to change education models and the practice of community based physicians for higher quality and more cost effective care, to be conducted by a new, freestanding medical school working in a collaborative model with an insurer, community hospitals, private practice physicians, and other health professionals.

SA 2972. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 731, between lines 16 and 17, insert the following:

''(xvii) Funding the use of telehealth systems to facilitate acute stroke therapy services furnished to Medicare beneficiaries in both rural and urban areas that are administered by board eligible or board certified vascular neurologists and coordinated by a certified stroke center.''.

SA 2973. Mrs. MURRAY (for herself and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

''Subpart XI—Community-Based Collaborative Care Network Program

''SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities for the purpose of establishing model projects to accomplish the following goals:

''(1) To reduce unnecessary use of items and services furnished in emergency departments of hospitals (especially to ensure that individuals without health insurance coverage or with inadequate health insurance coverage do not use the services of such department instead of the services of a primary care provider) through methods such as—

''(A) screening individuals who seek emergency department services for possible eligibility under relevant governmental health programs or for subsidies under such programs; and

''(B) providing such individuals referrals for followup care and chronic condition care.

''(2) To manage chronic conditions to reduce their severity, negative health outcomes, and expense.

''(3) To encourage health care providers to coordinate their efforts so that the most vulnerable patient populations seek and obtain primary care.

''(4) To provide more comprehensive and coordinated care to vulnerable low-income individuals and individuals without health insurance coverage or with inadequate coverage.

''(5) To provide mechanisms for improving both quality and efficiency of care for low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

''(6) To increase preventive services, including screening and counseling, to those who would otherwise not receive such screening, in order to improve health status and reduce long-term complications and costs.

''(7) To ensure the availability of community-wide safety net services, including emergency and trauma care.

''(b) ELIGIBILITY AND GRANTEE SELECTION.—

''(1) APPLICATION.—A community-based collaborative care network described in subsection (d) shall submit to the Secretary an application in such form and manner and containing such information as specified by the Secretary. Such information shall at least—

''(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant and, if a provider designated in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

''(B) include a description of how the providers plan to collaborate to provide comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

''(C) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made, and how the decision-making process of the network will include appropriate representation of the participating entities;

''(D) define the geographic areas and populations that the network intends to serve;

''(E) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3);

''(F) demonstrate the network's ability to meet the requirements of this section; and

''(G) provide assurances that grant funds received shall be used to support the entire community-based collaborative care network.

''(2) SELECTION OF GRANTEES.—

''(A) IN GENERAL.—The Secretary shall select community-based collaborative care networks to receive grants from applications submitted under paragraph (1) on the basis of quality of the proposal involved, geographic diversity (including different States and regions served and urban and rural diversity), and the number of low-income and uninsured individuals that the proposal intends to serve.

''(B) PRIORITY.—The Secretary shall give priority to proposals from community-based collaborative care networks that—

''(i) include the capability to provide the broadest range of services to low-income individuals; and

''(ii) include providers that currently serve a high volume of low-income individuals.

''(C) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

''(3) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services, if such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

''(4) TERMINATION AUTHORITY.—The Secretary may terminate selection of a community-based collaborative care network under this section for good cause. Such good cause shall include a determination that the network—

''(A) has failed to provide a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2);

''(B) has failed to meet reasonable quality standards;

''(C) has misappropriated funds provided under this section; or

''(D) has failed to make progress toward accomplishing goals set out in subsection (a).

''(c) USE OF FUNDS.—

''(1) USE BY GRANTEES.—Grant funds are provided to community-based collaborative care networks to carry out the following activities:

''(A) Assist low-income individuals without adequate health care coverage to—

''(i) access and appropriately use health services;

''(ii) enroll in applicable public or private health insurance programs;

''(iii) obtain referrals to and see a primary care provider in case such an individual does not have a primary care provider; and

''(iv) obtain appropriate care for chronic conditions.

''(B) Improve health care by providing case management, application assistance, and appropriate referrals such as through methods to—

''(i) create and meaningfully use a health information technology network to track patients across collaborative providers;

''(ii) perform health outreach, such as by using neighborhood health workers who may inform individuals about the availability of safety net and primary care providers available through the community-based collaborative care network;

''(iii) provide for followup outreach to remind patients of appointments or follow-up care instructions;

''(iv) provide transportation to individuals to and from the site of care;

''(v) expand the capacity to provide care at any provider participating in the community-based collaborative care network, including telehealth, hiring new clinical or administrative staff, providing access to services after-hours, on weekends, or otherwise providing an urgent care alternative to an emergency department; and

''(vi) provide a primary care provider or medical home for each network patient.

''(C) Provide direct patient care services as described in their application and approved by the Secretary.

''(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant

funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration (in this section referred to as 'HRSA') or impose other requirements on HRSA grantees participating in a community-based collaborative care network as may be necessary for consistency with the requirements of such programs.

''(3) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not more than 7 percent of funds appropriated to carry out this section for providing technical assistance to grantees, obtaining assistance of experts and consultants, holding meetings, developing of tools, disseminating of information, and evaluation.

''(d) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

''(1) IN GENERAL.—

''(A) DESCRIPTION.—A community-based collaborative care network described in this subsection is a consortium of health care providers with a joint governance structure that provides a comprehensive range of coordinated and integrated health care services for low-income patient populations or medically underserved communities (whether or not such individuals receive benefits under title XVIII, XIX, or XXI of the Social Security Act, private or other health insurance or are uninsured or underinsured) and that complies with any applicable minimum eligibility requirements that the Secretary may determine appropriate.

''(B) REQUIRED INCLUSION.—Each such network shall include the following providers that serve the community (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation)—

''(i) A safety net hospital that provides services to a high volume of low-income patients, as demonstrated by meeting the criteria in section 1923(b)(1) of the Social Security Act, or other similar criteria determined by the Secretary; and

''(ii) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))) located in the geographic area served by the Coordinated Care Network;

''(C) ADDITIONAL INCLUSIONS.—Funding preferences shall be given to networks that include additional providers such as the following:

''(i) A hospital, including a critical access hospital (as defined in section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2))).

''(ii) A county or municipal department of health.

''(iii) A rural health clinic or a rural health network (as defined in sections 1861(aa) and 1820(d) of the Social Security Act, respectively (42 U.S.C. 1395x(aa), 1395i–4(d))).

''(iv) A community clinic, including a mental health clinic, substance abuse clinic, or a reproductive health clinic.

''(v) A health center controlled network as defined by section 330(e)(1)(C) of the Public Health Service Act.

''(vi) A private practice physician or group practice.

''(vii) A nurse or physician assistant or group practice.

''(viii) An adult day care center.

''(ix) A home health provider.

''(x) Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

''(D) CONSTRUCTION.—

''(i) Nothing in this section shall prohibit a single entity from qualifying as community-based collaborative care network so long as such single entity meets the criteria of a community-based collaborative care network. If the network does not include the providers referenced in clauses (i) and (ii) of subparagraph (B) of this paragraph, the application must explain the reason pursuant to subsection (b)(1)(A).

''(ii) Participation in a community-based collaborative care network shall not affect Federally qualified health centers' obligation to comply with the governance requirements under section 330 of the Public Health Service Act (42 U.S.C. 254b).

''(iii) Federally qualified health centers participating in a community-based collaborative care network may not be required to provide services beyond their Federal Health Center scope of project approved by HRSA.

''(iv) Nothing in this section shall be construed to expand medical malpractice liability protection under the Federal Tort Claims Act for Section 330-funded Federally qualified health centers.

''(2) COMPREHENSIVE RANGE OF COORDINATED AND INTEGRATED HEALTH CARE SERVICES.—The Secretary shall define criteria for evaluating whether the services offered by a community-based collaborative care network qualify as a comprehensive range of coordinated and integrated health care services. Such criteria may vary based on the needs of the geographic areas and populations to be served by the network and may include the following:

''(A) Requiring community-based collaborative care networks to include at least the suggested core services identified under subsection (b)(3), or whichever subset of the suggested core services is applicable to a particular network.

''(B) Requiring such networks to assign each patient of the network to a primary care provider responsible for managing that patient's care.

''(C) Requiring the services provided by a community-based collaborative care network to include support services appropriate to meet the health needs of low-income populations in the network's community, which may include chronic care management, nutritional counseling, transportation, language services, enrollment counselors, social services and other services as proposed by the network.

''(D) Providing that the services provided by a community-based collaborative care network may also include long-term care services and other services not specified in this subsection.

''(E) Providing for the approval by the Secretary of a scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals available in the community the network serves.

''(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify a health care provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to services otherwise reimbursable under such title. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible to contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

''(e) EVALUATIONS.—

''(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation on the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

''(A) the number of people served;

''(B) the most common health problems treated;

''(C) any reductions in emergency department use;

''(D) any improvements in access to primary care;

''(E) an accounting of how amounts received were used, including identification of amounts used for patient care services as may be required for HRSA grantees; and

''(F) to the extent requested by the Secretary, any quality measures or any other measures specified by the Secretary.

''(2) PROGRAM REPORTS.—The Secretary shall submit to Congress an annual evaluation (beginning not later than 6 months after the first reports under paragraph (1) are submitted) on the extent to which emergency department use was reduced as a result of the activities carried out by the community-based collaborative care network under the program. Each such evaluation shall also include information on—

''(A) the prevalence of certain chronic conditions in various populations, including a comparison of such prevalence in the general population versus in the population of individuals with inadequate health insurance coverage;

''(B) demographic characteristics of the population of uninsured and underinsured individuals served by the community-based collaborative care network involved; and

''(C) the conditions of such individuals for whom services were requested at such emergency departments of participating hospitals.

''(3) AUDIT AUTHORITY.—The Secretary may conduct periodic audits and request periodic spending reports of community-based collaborative care networks under the community-based collaborative care network program.

''(f) CLARIFICATION.—Nothing in this section requires a provider to report individually identifiable information of an individual to government agencies, unless the individual consents, consistent with HIPAA privacy and security law, as defined in section 3009(a)(2).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SA 2974. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 114, beginning with line 17, strike all through page 116, line 6, and insert the following:

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if the plan provides —

(A) except as provided in subparagraph (B), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until

the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(B) coverage for at least three primary care visits.

(2) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

On page 155, beginning with line 22, strike all through page 156, line 3, and insert the following:

(A) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan.

On page 250, lines 7 through 10, strike '', except that such term shall not include a qualified health plan which is a catastrophic health plan described in section 1302(e) of such Act''.

SA 2975. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 348, strike line 22 and all that follows through line 15 on page 349.

SA 2976. Mr. CARDIN (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3115. PERMITTING HOME HEALTH AGENCIES TO ASSIGN THE MOST APPROPRIATE SKILLED SERVICE TO MAKE THE INITIAL ASSESSMENT VISIT UNDER A MEDICARE HOME HEALTH PLAN OF CARE FOR REHABILITATION CASES.

(a) IN GENERAL.—Notwithstanding section 484.55(a)(2) of title 42 of the Code of Federal Regulations or any other provision of law, a home health agency may determine the most appropriate skilled therapist to make the initial assessment visit for an individual who is referred (and may be eligible) for home health services under title XVIII of the Social Security Act but who does not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act on the basis of a need for occupational therapy.

SA 2977. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 4208. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

(a) FINDINGS.—Congress finds as follows:

(1) Access to health care in the State of Alaska is challenging due to geographical constraints, health care workforce and treatment facility shortages, and lack of certain medical specialties available in the State.

(2) Delivery of health care to beneficiaries of Federal health care programs is especially challenging in the State of Alaska as a result of capacity constraints at Federal treatment facilities and insufficient civilian provider networks to support Federal systems.

(3) The State of Alaska has the largest, per capita population of veterans, many of whom rely on the health care system of the Department of Veterans Affairs.

(4) The State of Alaska has a large population of active-duty military personnel, military retirees, and dependents of military personnel and retirees who rely on the military health care system. This population will increase as a result of Armed Forces structure initiatives during the next several years.

(5) A significant portion of Alaska's population is comprised of Medicare beneficiaries.

(6) Almost ¼ of Alaska's population is comprised of Medicaid beneficiaries.

(7) Federal agencies have undertaken efforts to improve and increase access to health care in the State of Alaska for Federal health care system beneficiaries, but there are finite medical resources in the State for which such beneficiaries must compete.

(8) To ensure improved and increased access to health care for beneficiaries of Federal health care systems in the State of Alaska, comprehensive policies and interagency collaboration are required.

(b) INTERAGENCY ACCESS TO HEALTH CARE IN ALASKA TASK FORCE.—

(1) ESTABLISHMENT.—There is established a task force to be known as the ''Interagency Access to Health Care in Alaska Task Force'' (referred to in this section as the ''Task Force'').

(2) ACTIVITIES.—The Task Force shall—

(A) assess access to health care for beneficiaries of Federal health care systems in Alaska, which shall include consideration of, with regard to the State of Alaska—

(i) current Federal health care delivery methods at Federal treatment facilities and through civilian provider networks;

(ii) shortfalls in delivering health care to beneficiaries of Federal health care systems at Federal treatment facilities and through civilian provider networks; and

(iii) the impact of reimbursement rates and claims processing on civilian provider participation; and

(B) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska, which shall include—

(i) interagency collaboration opportunities for addressing shortfalls in delivering health care to beneficiaries of Federal health care systems;

(ii) increasing Federal Government primary care and specialty care capability practices in the State of Alaska at Federal treatment facilities and in the civilian provider community.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—

(A) FEDERAL MEMBERS.—The Task Force shall be comprised of Federal members who shall be appointed as follows:

(i) One member shall be a representative of the Department of Health and Human Services and shall be appointed by the Secretary of Health and Human Services.

(ii) One member shall be a representative of the Centers for Medicare and Medicaid Services and shall be appointed by the Secretary of Health and Human Services.

(iii) One member shall be a representative of the Indian Health Service and shall be appointed by the Secretary of Health and Human Services.

(iv) One member shall be a representative of the TRICARE Management Activity and shall be appointed by the Secretary of Defense.

(v) One member shall be a representative of the Army Medical Department and shall be appointed by the Secretary of the Army.

(vi) One member shall be a representative of the Air Force and shall be appointed by the Secretary of the Air Force from among officers at the Air Force performing medical service functions.

(vii) One member shall be a representative of the Department of Veterans Affairs and shall be appointed by the Secretary of Veterans Affairs.

(viii) One member shall be a representative of the Veterans Health Administration and shall be appointed by the Secretary of Veterans Affairs.

(ix) One member shall be a representative of the United States Coast Guard and shall be appointed by the Secretary of Homeland Security.

(B) NON-FEDERAL MEMBERS.—Individuals appointed by the Secretary of Health and Human Services to the Task Force from outside the agencies may include officers or employees of other departments and agencies of the Federal Government and individuals from the private medical community in Alaska and, at the election of the Governor of the State of Alaska, shall include at least one employee representative of the State of Alaska.

(2) TIMEFRAME FOR APPOINTMENT.—All appointments of individuals to the Task Force, as described in paragraph (2), shall be made not later than 45 days after the date of enactment of this Act.

(3) CO-CHAIRPERSONS.—There shall be 2 co-chairpersons of the Task Force, appointed at the time of appointment of members under paragraph (1). One co-chairperson shall be designated by the Secretary of Health and Human Services from among the representatives of the Department of Health and Human Services who are appointed to the Task Force under clauses (i) through (iii) of paragraph (2), and one co-chairperson shall be designated by the Secretary of Health and Human Services from among the members appointed under clauses (iv) through (ix) of such paragraph.

(4) VACANCIES.—A vacancy in the Task Force shall be filled in the manner in which the original appointment was made.

(5) COMPENSATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), members of the Task Force may not receive pay, allowances, or benefits by reason of such member's service on the Task Force.

(B) TRAVEL EXPENSES.—The members of the Task Force shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Task Force.

(d) MEETINGS.—The Task Force shall meet at the call of the chairperson.

(e) REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duties of the Task Force under subsection (b)(2).

(2) CONSIDERATION OF OTHER EFFORTS.—In preparing the report described in paragraph (1), the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

(f) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (e).

SA 2978. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 3510, insert the following:

SEC. 3511. ASSISTANCE FOR FRONTIER CLINICS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 4303, is further amended by adding at the end the following:

"PART V—ASSISTANCE FOR FRONTIER CLINICS

"SEC. 399NN. ASSISTANCE FOR FRONTIER CLINICS.

''(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary'), acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible health clinics for the purpose of ensuring access to needed emergency care in frontier areas 24-hours per day, 7 days per week, and to ensure the health and safety of patients at such clinics.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall be—

''(1) located in a community where the closest short-term acute care hospital or critical access hospital is—

''(A) at least 60 miles or one hour usual travel time from such community; or

''(B) inaccessible by public road; and

''(2) designed to address the needs of—

''(A) seriously or critically ill or injured patients for stabilization prior to transport to definitive care; or

''(B) patients who need monitoring and observation for a limited period of time.

''(c) PRIORITY.—In awarding grants under this section, the Secretary shall ensure that not less than 25 percent of the entities receiving such a grant are located in communities from which the nearest short-term acute care hospital or critical access hospital is at least 75 miles or is inaccessible by public road.

''(d) USE OF FUNDS.—Entities receiving a grant under this section shall use such grant funds to meet quality standards established for the staffing, equipment, or health care facility of such entity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2011 through 2015.''.

SA 2979. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After title IX, insert the following:

TITLE X—INCREASING ACCESS TO PRIMARY CARE SERVICES

SEC. 10001. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.

(a) IN GENERAL.—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

(b) SOURCE OF FUNDS.—A grant program established by a State under subsection (a) may not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).

SEC. 10002. INCENTIVE PAYMENTS FOR PRIMARY CARE PHYSICIANS WHO TREAT A CERTAIN PERCENTAGE OF NEW MEDICARE PATIENTS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 5501, is further amended by adding at the end the following new subsection:

''(z) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES PROVIDED TO NEW MEDICARE PATIENTS.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by an eligible primary care practitioner in a calendar year, in addition to the amount of payment that would otherwise be made for such services under this part, including any payment available under subsection (x), there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection—

''(A) the term 'eligible primary care provider' means a primary care practitioner for whom, of all patients for whom such practitioner provides primary care services in a calendar year and for whom such practitioner did not provide such services in the previous calendar year, 10 percent of such patients are enrollees under this part;

''(B) the terms 'primary care practitioner' and 'primary care services' have the meanings given such terms in subsection (x)(2).

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsections (m) and (x) shall be determined without regard to any additional payment for the service under subsection (m), subsection (x), and this subsection, respectively.

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by section 5501(b)(2), is further amended by striking ''(x) and (y)'' in the last sentence and inserting ''(x), (y), and (z)''.

(2) Section 1834(x)(3) of such Act, as added by section 5501, is amended—

(A) by striking ''subsection (m)'' the first place it appears and inserting ''subsections (m) and (z)''; and

(B) by striking ''subsection (m) and'' and inserting ''subsection (m), subsection (z), and''.

SEC. 10003. FACULTY LOAN REPAYMENT FOR PHYSICIAN ASSISTANTS.

Section 738(a)(3) of the Public Health Service Act (42 U.S.C.293b(a)(3)) is amended by inserting ''schools offering physician assistant education programs,'' after ''public health,''.

SEC. 10004. ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

Section 1899(b)(2)(D) of the Social Security Act, as added by section 3022, is amended by adding at the end: ''Notwithstanding the preceding sentence, the Secretary may approve for participation in the program any ACO, with any number of Medicare fee-for-service beneficiaries assigned to such ACO, that proposes a plan that would improve efficiencies and provide cost savings.''

SEC. 10005. AMERICAN PRIMARY CARE CORPS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish an American Primary Care Corps (referred to in this section as the ''program'') for the purpose of encouraging health care practitioners who are recent graduates of a health care program to enter into primary care practice, by providing incentive payments to eligible primary care practitioners.

(b) DEFINITIONS.—In this section:

(1) PRIMARY CARE PRACTITIONER.—The term ''primary care practitioner'' means a health care provider, including a physician, dentist, nurse practitioner, and physician assistant, who primarily provides primary health services.

(2) PRIMARY CARE SERVICES.—The term ''primary health services'' has the meaning given such term in section 331(a)(3)(D) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(D)).

(c) PROGRAM.—

(1) IN GENERAL.—The Secretary shall select recipients of the incentive payment awards under this section from among eligible primary care practitioners. Each recipient of such an award shall receive incentive payments, as described in paragraph (2), for a period of 3 years, provided such recipient continues to maintain active employment as a primary care practitioner.

(2) INCENTIVE PAYMENTS.—The Secretary shall award incentive payments, on a competitive basis, to eligible primary care practitioners as follows:

(A) In the first year that a practitioner receives an award under the program, such practitioner shall receive an incentive payment in an amount that is equal to 75 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(B) In the second year that a practitioner receives an award under the program, such practitioner shall receive an incentive payment in an amount that is equal to 50 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(C) In the third year that a practitioner receives an award under the program, such

practitioner shall receive an incentive payment in an amount that is equal to 25 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(d) ELIGIBLE PRIMARY CARE PRACTITIONERS.—To be eligible to receive an incentive payment under this section, an individual shall—

(1) be actively employed as a primary care practitioner, or have arrangements to commence active employment as a primary care practitioner;

(2) have graduated, not more than 2 years after the date on which such individual would begin receiving incentive payments under this program, from an accredited program that qualifies such individual to maintain employment as a primary care practitioner; and

(3) submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(e) DURATION OF PROGRAM.—The Secretary shall make awards under this section for each of fiscal years 2011 through 2015. Each such recipient shall remain in the program for a 3-year period, as described in subsection (c), provided such recipient continues to maintain active employment as a primary care practitioner.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015, and such sums as may be necessary for fiscal years 2016 and 2017.

SA 2980. Ms. MIKULSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 84, line 10, insert ''sterilization'' after ''including''.

On page 95, between lines 7 and 8, insert the following:

''SEC. 2705A. PROHIBITING CONSIDERATION OF PRIOR HISTORY OF STERILIZATION, DOMESTIC VIOLENCE, OR MEDICALLY NECESSARY CESAREAN SECTION AS A CONDITION FOR ISSUING HEALTH INSURANCE COVERAGE.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not, with respect to an individual desiring to enroll in coverage, take any of the following actions based on evidence of sterilization, domestic violence, or medically necessary cesarean section with respect to such individual:

''(1) Decline to offer coverage to such individual.

''(2) Deny enrollment of such individual in the lan or coverage.

''(3) Establish rules of eligibility (including continued eligibility) for such individual under the plan or coverage.

''(4) Require such individual to pay an additional premium or contribution amount based solely on evidence of sterilization.

''(5) Require sterilization as a condition to offer coverage.''.

On page 99, line 23, insert before the period the following: '', except that the provisions of section 2705A of the Public Health Service Act (as added by such amendments) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act''.

SA 2981. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 19, line 19, insert before the period the following: ''and for form and rate filings with respect to issuers''.

On page 24, line 14, insert ''(including standards relating to form and rate fillings)'' after ''section''.

SA 2982. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 621, between lines 9 and 10, insert the following:

SEC. 2956. INFANT EYE AND VISION ASSESSMENT.

(a) INCLUSION IN MATERNAL AND CHILD HEALTH SERVICES PROGRAM.—Subsection (a)(2) of section 501 of the Social Security Act (42 U.S.C. 701) is amended—

(1) by striking ''and'' after ''without regard to age,''; and

(2) by inserting after ''follow-up services'' the following: '', and for infant eye and vision assessment promotion''.

(b) DEFINITION.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

''(5) The term 'infant eye and vision assessment promotion' means a nationally established program for the promotion of—

''(A) comprehensive eye and vision assessments provided to infants who have attained 6 months, but not 12 months, in age without charge;

''(B) the development and dissemination of parental information and education materials on infant eye and vision health;

''(C) increased participation by optometrists to perform infant eye and vision assessments; and

''(D) public and private partnerships at the State and local levels for the provision of such eye and vision assessments.''.

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

SA 2983. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1265, between lines 8 and 9, insert the following:

SEC. 4307. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

''SEC. 544. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

''(a) PROGRAM.—The Secretary, acting through the Administrator, shall establish a program (consisting of awarding grants, contracts, and cooperative agreements under subsection (b)) on mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary health care settings.

''(b) USE OF FUNDS.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, entities—

''(1) to provide mental health and substance abuse screening, brief interventions, referral, and recovery services;

''(2) to coordinate such services with primary health care services in the same program and setting;

''(3) to develop a network of facilities to which patients may be referred if needed;

''(4) to purchase needed screening and other tools that are—

''(A) necessary for providing such services; and

''(B) supported by evidence-based research; and

''(5) to maintain communication with appropriate State mental health and substance abuse agencies.

''(c) ELIGIBILITY.—To be eligible for a grant, contract, or cooperative agreement under this section, an entity shall be a public or private nonprofit entity that—

''(1) provides primary health services;

''(2) seeks to integrate mental health and substance abuse services into its service system;

''(3) has developed a working relationship with providers of mental health and substance abuse services;

''(4) demonstrates a need for the inclusion of mental health and substance abuse services in its service system; and

''(5) agrees—

''(A) to prepare and submit to the Secretary at the end of the grant, contract, or cooperative agreement period an evaluation of all activities funded through the grant, contract, or cooperative agreement; and

''(B) to use such performance measures as may be stipulated by the Secretary for purposes of such evaluation.

''(d) PREFERENCE.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall give preference to entities that—

''(1) provide services in rural or underserved areas of the United States;

''(2) provide services to entities in States that have high percentages of populations with substance abuse or mental health problems; or

''(3) provide services in school-based health clinics or on university and college campuses.

''(e) DURATION.—The period of a grant, contract, or cooperative agreement under this section may not exceed 5 years.

''(f) REPORT.—Not later than 4 years after the first appropriation of funds to carry out this section, the Secretary shall submit a report to the Congress on the program under this section—

''(1) that includes an evaluation of the benefits of integrating mental health and substance abuse care within primary health care; and

''(2) focusing on the performance measures stipulated by the Secretary under subsection (c)(5).

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated $30,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

''(2) PROGRAM MANAGEMENT.—Of the funds appropriated to carry out this section for a fiscal 5 year, the Secretary may use not more than 5 percent to manage the program under this section.''.

SA 2984. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3115. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.

(a) IN GENERAL.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a) is amended to read as follows:

''(b) CLARIFICATION OF USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.—

''(1) IN GENERAL.—Nothing in this title shall prohibit a medicare beneficiary from entering into a private contract with a physician or health care practitioner for the provision of medicare covered professional services (as defined in paragraph (5)(C)) if—

''(A) the services are covered under a private contract that is between the beneficiary and the physician or practitioner and meets the requirements of paragraph (2);

''(B) under the private contract no claim for payment for services covered under the contract is to be submitted (and no payment made) under part A or B, under a contract under section 1876, or under an MA plan (other than an MSA plan); and

''(C)(i) the Secretary has been provided with the minimum information necessary to avoid any payment under part A or B for services covered under the contract, or

''(ii) in the case of an individual enrolled under a contract under section 1876 or an MA plan (other than an MSA plan) under part C, the eligible organization under the contract or the MA organization offering the plan has been provided the minimum information necessary to avoid any payment under such contract or plan for services covered under the contract.

''(2) REQUIREMENTS FOR PRIVATE CONTRACTS.—The requirements in this paragraph for a private contract between a medicare beneficiary and a physician or health care practitioner are as follows:

''(A) GENERAL FORM OF CONTRACT.—The contract is in writing and is signed by the medicare beneficiary.

''(B) NO CLAIMS TO BE SUBMITTED FOR COVERED SERVICES.—The contract provides that no party to the contract (and no entity on behalf of any party to the contract) shall submit any claim for (or request) payment for services covered under the contract under part A or B, under a contract under section 1876, or under an MA plan (other than an MSA plan).

''(C) SCOPE OF SERVICES.—The contract identifies the medicare covered professional services and the period (if any) to be covered under the contract, but does not cover any services furnished—

''(i) before the contract is entered into; or

''(ii) for the treatment of an emergency medical condition (as defined in section 1867(e)(1)(A)), unless the contract was entered into before the onset of the emergency medical condition.

''(D) CLEAR DISCLOSURE OF TERMS.—The contract clearly indicates that by signing the contract the medicare beneficiary—

''(i) agrees not to submit a claim (or to request that anyone submit a claim) under part A or B (or under section 1876 or under an MA plan, other than an MSA plan) for services covered under the contract;

''(ii) agrees to be responsible, whether through insurance or otherwise, for payment for such services and understands that no reimbursement will be provided under such part, contract, or plan for such services;

''(iii) acknowledges that no limits under this title (including limits under paragraphs (1) and (3) of section 1848(g)) will apply to amounts that may be charged for such services;

''(iv) acknowledges that medicare supplemental policies under section 1882 do not, and other supplemental health plans and policies may elect not to, make payments for such services because payment is not made under this title; and

''(v) acknowledges that the beneficiary has the right to have such services provided by (or under the supervision of) other physicians or health care practitioners for whom payment would be made under such part, contract, or plan.

Such contract shall also clearly indicate whether the physician or practitioner involved is excluded from participation under this title.

''(3) MODIFICATIONS.—The parties to a private contract may mutually agree at any time to modify or terminate the contract on a prospective basis, consistent with the provisions of paragraphs (1) and (2).

''(4) NO REQUIREMENTS FOR SERVICES FURNISHED TO MSA PLAN ENROLLEES.—The requirements of paragraphs (1) and (2) do not apply to any contract or arrangement for the provision of services to a medicare beneficiary enrolled in an MSA plan under part C.

''(5) DEFINITIONS.—In this subsection:

''(A) HEALTH CARE PRACTITIONER.—The term 'health care practitioner' means a practitioner described in section 1842(b)(18)(C).

''(B) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is enrolled under part B.

''(C) MEDICARE COVERED PROFESSIONAL SERVICES.—The term 'medicare covered professional services' means—

''(i) physicians' services (as defined in section 1861(q), and including services described in section 1861(s)(2)(A)), and

''(ii) professional services of health care practitioners, including services described in section 1842(b)(18)(D),

for which payment may be made under part A or B, under a contract under section 1876, or under a Medicare Advantage plan but for the provisions of a private contract that meets the requirements of paragraph (2).

''(D) MA PLAN; MSA PLAN.—The terms 'MA plan' and 'MSA plan' have the meanings given such terms in section 1859.

''(E) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r).''.

(b) CONFORMING AMENDMENTS CLARIFYING EXEMPTION FROM LIMITING CHARGE AND FROM REQUIREMENT FOR SUBMISSION OF CLAIMS.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w–4(g)) is amended—

(1) in paragraph (1)(A), by striking ''In'' and inserting ''Subject to paragraph (8), in'';

(2) in paragraph (3)(A), by striking ''Payment'' and inserting ''Subject to paragraph (8), payment'';

(3) in paragraph (4)(A), by striking ''For'' and inserting ''Subject to paragraph (8), for''; and

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

''(8) EXEMPTION FROM REQUIREMENTS FOR SERVICES FURNISHED UNDER PRIVATE CONTRACTS.—

''(A) IN GENERAL.—Pursuant to section 1802(b)(1), paragraphs (1), (3), and (4) do not apply with respect to physicians' services (and services described in section 1861(s)(2)(A)) furnished to an individual by (or under the supervision of) a physician if the conditions described in section 1802(b)(1) are met with respect to the services.

''(B) NO RESTRICTIONS FOR ENROLLEES IN MSA PLANS.—Such paragraphs do not apply with respect to services furnished to individuals enrolled with MSA plans under part C, without regard to whether the conditions described in subparagraphs (A) through (C) of section 1802(b)(1) are met.

''(C) APPLICATION TO ENROLLEES IN OTHER PLANS.—Subject to subparagraph (B) and section 1852(k)(2), the provisions of subparagraph (A) shall apply in the case of an individual enrolled under a contract under section 1876 or under an MA plan (other than an MSA plan) under part C, in the same manner as they apply to individuals not enrolled under such a contract or plan.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) is amended by adding at the end the following:

''(E) The provisions of section 1848(g)(8) shall apply with respect to exemption from limitations on charges and from billing requirements for services of health care practitioners described in this paragraph in the same manner as such provisions apply to exemption from the requirements referred to in section 1848(g)(8)(A) for physicians' services.''.

(2) Section 1866(a)(1)(O) of such Act (42 U.S.C. 1395cc(a)(1)(O)) is amended by striking ''enrolled with a Medicare Advantage organization under part C'' and inserting ''enrolled with an MA organization under part C (other than under an MSA plan)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 6 months after the date of the enactment of this Act and apply to contracts entered into on or after that date.

SA 2985. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. ___. CONTINUED ABILITY TO PAY FOR HEALTH CARE.

Nothing in this title (or an amendment made by this title) shall be construed to prohibit an individual from purchasing or otherwise paying for health care items or services on an out-of-pocket basis.

SA 2986. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr.

DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 201, between lines 6 and 7, insert the following:

SEC. 1325. PROVIDER CHOICE.

Notwithstanding any other provision of this title, a Consumer Operated and Oriented Plan under section 1322 and a community health insurance option under section 1323 shall not require the participation of health care providers. The participation of such providers shall be on a voluntary basis.

SA 2987. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. ___. PROTECTING THE TAXPAYERS.

The provisions of this title (and the amendments made by this title) shall not apply with respect to a fiscal year if the Director of the Office of Management and Budget fails to certify to Congress that the application of such provisions (and amendments) in such fiscal year will not increase the Federal budget deficit.

SA 2988. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 320, beginning with line 19, strike all through page 340, line 21.

SA 2989. Mr. MENENDEZ (for himself, Mr. SCHUMER, Mr. DODD, Mrs. GILLIBRAND, Mr. KERRY, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 128, line 6, insert '', and includes, as elected under and subject to section 10001, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands''.

Strike section 2005.

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

TITLE X—PROVISIONS RELATING TO THE TERRITORIES

SEC. 10001. SPECIAL RULES FOR APPLICATION OF TITLE I TO TERRITORIES.

(a) ONE-TIME ELECTION FOR TREATMENT AND APPLICATION OF FUNDING.—

(1) IN GENERAL.—A territory may elect, in a form and manner specified by the Secretary of Health and Human Services jointly with the Secretary of the Treasury, and not later than October 1, 2013, either—

(A) to be treated as a State for purposes of applying title I (including establishing an Exchange for such territory); or

(B) not to be so treated but instead, to have the dollar limitation otherwise applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year increased by a dollar amount equivalent to the cap amount determined under subsection (c)(2) for the territory as applied by the Secretary for the fiscal year involved.

(2) CONDITIONS FOR ACCEPTANCE.—The Secretary of Health and Human Services has the nonreviewable authority to accept or reject an election described in paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in subsection (b) between the Secretary of Health and Human Services and the territory and subsection (c); and

(B) subject to the approval of the Secretary of Health and Human Services and the Secretary of the Treasury and subject to such other terms and conditions as the Secretaries may specify.

(3) DEFAULT RULE.—A territory failing to make such an election (or having an election under paragraph (1)(A) not accepted under paragraph (2)) shall be treated as having made the election described in paragraph (1)(B).

(b) AGREEMENT FOR SUBSTITUTION OF PERCENTAGES FOR REDUCTION IN COST-SHARING.—

(1) NEGOTIATION.—In the case of a territory making an election under subsection (a)(1)(A) (in this section referred to as an ''electing territory''), the Secretaries of Health and Human Services and the Treasury shall enter into negotiations with the government of such territory so that, prior to January 1, 2014, there is an agreement reached between the parties on the percentages that shall be applied under paragraph (2) for that territory. The Secretary of Health and Human Services shall not enter into such an agreement unless—

(A) payments made under title I (and the amendments made by such title) with respect to residents of the territory are consistent with the cap established under subsection (c) for such territory and with subsection (d); and

(B) the requirements of paragraphs (3) and (4) are met.

(2) APPLICATION OF SUBSTITUTE PERCENTAGES AND DOLLAR AMOUNTS.—In the case of an electing territory, there shall be substituted in section 1402(b)(2) and section 36B of the Internal Revenue Code of 1986 for 400 percent, 133 percent, and other percentages and dollar amounts specified in such sections, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:

(A) NO INCOME GAP BETWEEN MEDICAID AND REDUCTION IN COST-SHARING.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between the income level at which medical assistance is available through Medicaid and the income level at which reduced cost-sharing is available under section 1402.

(B) ADJUSTMENT FOR OUT-OF-POCKET RESPONSIBILITY FOR PREMIUMS AND COST-SHARING IN RELATION TO INCOME.—The substituted percentages of the Federal poverty line for income tiers under such sections shall be specified in a manner so that—

(i) individuals eligible for reduced cost-sharing under section 1402 residing in the territory bear the same out-of-pocket responsibility for premiums and cost-sharing in relation to average income for residents in that territory, as

(ii) the out-of-pocket responsibility for premiums and cost-sharing for individuals eligible for reduced cost-sharing under section 1402 residing in the 50 States or the District of Columbia in relation to average income for such residents.

In the case of a territory with a mirror code tax system, the Internal Revenue Code of 1986 shall be applied as if the substitutions permitted under this paragraph were included in such Code.

(3) SPECIAL RULES WITH RESPECT TO APPLICATION OF TAX AND PENALTY PROVISIONS.—The electing territory shall enact one or more laws under which provisions similar to the following provisions apply with respect to such territory:

(A) Section 5000A of the Internal Revenue Code of 1986, except that any resident of the territory who is not eligible for reduced cost-sharing under section 1402 but who would be so eligible if such resident were a resident of one of the 50 States (and any qualifying child residing with such individual) may be treated as covered by minimum essential coverage.

(B) Section 502(c)(11) of the Employee Retirement Income Security Act of 1974.

(C) Section 3121(c) of the Internal Revenue Code of 1986.

(4) IMPLEMENTATION OF INSURANCE REFORM AND CONSUMER PROTECTION REQUIREMENTS.—The electing territory shall enact and implement such laws and regulations as may be required to apply the requirements of subtitles A and C of title I (and the amendments made by such subtitles) with respect to health insurance coverage offered in the territory.

(c) CAP ON ADDITIONAL EXPENDITURES.—

(1) IN GENERAL.—In entering into an agreement with an electing territory under subsection (b), the Commissioner shall ensure that the aggregate expenditures under this section with respect to residents of such territory during the period beginning on January 1, 2014 and ending with 2019 will not exceed the cap amount specified in paragraph (2) for such territory. The Commissioner shall adjust from time to time the percentages applicable under such agreement as needed in order to carry out the previous sentence.

(2) CAP AMOUNT.—

(A) IN GENERAL.—The cap amount specified in this paragraph—

(i) for Puerto Rico is $3,700,000,000 increased by the amount (if any) elected under subparagraph (C); or

(ii) for another territory is the portion of $300,000,000 negotiated for such territory under subparagraph (B).

(B) NEGOTIATION FOR CERTAIN TERRITORIES.—The Secretary of Health and Human Services shall negotiate with the governments of the territories (other than Puerto Rico) to allocate the amount specified in subparagraph (A)(ii) among such territories.

(C) OPTIONAL SUPPLEMENTATION FOR PUERTO RICO.—

(i) IN GENERAL.—Puerto Rico may elect, in a form and manner specified by the Secretary of Health and Human Services to increase the dollar amount specified in subparagraph (A)(i) by up to $1,000,000,000.

(ii) OFFSET IN MEDICAID CAP.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease the dollar

limitation otherwise applicable to Puerto Rico under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year by the additional aggregate payments the Secretary estimates will be payable under this section for the fiscal year because of such election.

(d) LIMITATION ON FUNDING.—In no case shall this section (including the agreement under subsection (b)) permit—

(1) the obligation of funds for expenditures under this section for periods beginning on or after January 1, 2020; or

(2) any increase in the dollar limitation described in subsection (a)(1)(B) for any portion of any fiscal year occurring on or after such date.

SEC. 10002. MEDICAID PAYMENTS TO TERRITORIES.

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(2) in subsection (g)(1), by striking ''With respect to'' and inserting ''Subject to subsection (h), with respect to''; and

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

''(h) ADDITIONAL INCREASE FOR FISCAL YEARS 2011 THROUGH 2019.—Subject to section 10002(b)(1) of the Patient Protection and Affordable Care Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsections (f) and (g) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa shall be increased by the following amounts:

''(1) For Puerto Rico, for fiscal year 2011, $727,600,000; for fiscal year 2012, $775,000,000; for fiscal year 2013, $850,000,000; for fiscal year 2014, $925,000,000; for fiscal year 2015, $1,000,000,000; for fiscal year 2016, $1,075,000,000; for fiscal year 2017, $1,150,000,000; for fiscal year 2018, $1,225,000,000; and for fiscal year 2019, $1,396,400,000.

''(2) For the Virgin Islands, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(3) For Guam, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(4) For the Northern Mariana Islands, for fiscal year 2011, $13,500,000; fiscal year 2012, $14,500,000; for fiscal year 2013, $15,500,000; for fiscal year 2014, $16,500,000; for fiscal year 2015, $17,500,000; for fiscal year 2016, $18,500,000; for fiscal year 2017, $19,500,000; for fiscal year 2018, $21,000,000; and for fiscal year 2019, $22,000,000.

''(5) For American Samoa, fiscal year 2011, $22,000,000; fiscal year 2012, $23,687,500; for fiscal year 2013, $24,687,500; for fiscal year 2014, $25,687,500; for fiscal year 2015, $26,687,500; for fiscal year 2016, $27,687,500; for fiscal year 2017, $28,687,500; for fiscal year 2018, $29,687,500; and for fiscal year 2019, $30,687,500.''.

(b) REPORT ON ACHIEVING MEDICAID PARITY PAYMENTS BEGINNING WITH FISCAL YEAR 2020.—

(1) IN GENERAL.—Not later than October 1, 2013, the Secretary of Health and Human Services shall submit to Congress a report that details a plan for the transition of each territory to full parity in Medicaid with the 50 States and the District of Columbia in fiscal year 2020 by modifying their existing Medicaid programs and outlining actions the Secretary and the governments of each territory must take by fiscal year 2020 to ensure parity in financing. Such report shall include what the Federal medical assistance percentages would be for each territory if the formula applicable to the 50 States were applied. Such report shall also include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided for in section 1108 of the Social Security Act (42 U.S.C. 1308) should be increased any time before fiscal year 2020 due to any factors that the Secretary deems relevant.

(2) PER CAPITA DATA.—As part of such report the Secretary shall include information about per capita income data that could be used to calculate Federal medical assistance percentages under section 1905(b) of the Social Security Act, under section 1108(a)(8)(B) of such Act, for each territory on how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical assistance percentages can be calculated for the territories beginning in fiscal year 2020 to ensure parity with the 50 States.

(3) SUBSEQUENT REPORTS.—The Secretary shall submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined in the plan submitted under paragraph (1).

(c) APPLICATION OF FMAP FOR ADDITIONAL FUNDS.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following sentence: ''Notwithstanding the first sentence of this subsection and any other provision of law, for fiscal years 2011 through 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of section 5001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and the District for calendar quarters during such fiscal years for which such subsections apply.''.

(d) WAIVERS.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa''; and

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning with fiscal year 2011.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide nonmonetary technical assistance to the governments of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in upgrading their existing computer systems in order to anticipate meeting reporting requirements necessary to implement the plan contained in the report under subsection (b)(1).

SEC. 10003. MEDICARE PROVISIONS RELATING TO PUERTO RICO.

(a) MODIFICATION OF MEDICARE INPATIENT HOSPITAL PAYMENT RATE FOR PUERTO RICO HOSPITALS.—Section 1886(d)(9)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(E)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv), by inserting ''and before April 1, 2010,'' after ''2004,'' and by striking the period at the end and inserting ''; and''; and

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

''(v) on or after April 1, 2010, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.''.

(b) APPLICATION OF DEEMED PART B MEDICARE ENROLLMENT RULES TO RESIDENTS OF PUERTO RICO.—

(1) IN GENERAL.—Section 1837(f)(3) of the Social Security Act (42 U.S.C. 1395p(f)(3)) is amended by striking '', exclusive of Puerto Rico''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to individuals whose initial enrollment period under section 1837(d) of the Social Security Act (42 U.S.C. 1395p(d)) begins on or after the first day of the first month that begins more than 60 days after the date of the enactment of this Act.

SA 2990. Mr. MENENDEZ submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

''(10) federally approved and recommended vaccines (as defined in subsection (hhh)) and their respective administration;''.

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is amended by adding at the end the following new subsection:

''Federally Approved and Recommended Vaccines

''(hhh) The term 'federally approved and recommended vaccine' means a vaccine that—

''(1) is licensed under section 351 of the Public Health Service Act, approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

''(2) is recommended by the Director of the Centers for Disease Control and Prevention.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking ''1861(s)(10)(A)'' and inserting ''1861(s)(10)'' each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking ''subparagraph (A) or (B) of''; and

(B) by inserting before the period the following: ''and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011''.

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting '', including a vaccine furnished on or after January 1, 2010''; and

(B) by the following new paragraph:

''(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) or subsection (f)(2) for purposes of implementation of this section.''.

(4) Section 1860D–2(e)(1) of such Act (42 U.S.C. 1395w–102(e)(1)) is amended by striking ''such term includes a vaccine'' and all that follows through ''its administration) and''.

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking ''Pneumococcal, influenza, and hepatitis B vaccine and administration'' and inserting ''federally approved or authorized vaccines (as defined in subsection (hhh)) and their respective administration''.

(6) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting ''(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),'' after ''described in subparagraph''.

(7) Section 1847A(f) of such Act (42 U.S.C. 1395w–3a(f)) is amended—

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

(B) by indenting paragraph (1), as redesignated in subparagraph (A), 2 ems to the left; and—

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

''(2) TREATMENT OF CERTAIN MANUFACTURERS.—In the case of a manufacturer of a drug or biological described in subparagraphs (A)(iv), (C), (D), (E), or (G) of section 1842(o)(1) that does not have a rebate agreement under section 1927(a), no payment may be made under this part for such drug or biological if such manufacturer does not submit the information described in section 1927(b)(3)(A)(iii) in the same manner as if the manufacturer had such a rebate agreement in effect. Subparagraphs (C) and (D) of section 1927(b)(3) shall apply to information reported pursuant to the previous sentence in the same manner as such subparagraphs apply with respect to information reported pursuant to such section.''.''.

(d) EFFECTIVE DATES.—The amendments made—

(1) by this section (other than by subsection (c)(6)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(6) shall apply to calendar quarters beginning on or after January 1, 2010.

SA 2991. Mr. MENENDEZ (for himself, Mr. ROCKEFELLER, Mr. BINGAMAN, and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. PERMITTING STATES TO ENSURE COVERAGE WITHOUT A 5-YEAR DELAY OF LAWFULLY RESIDING NONCITIZEN NONPREGNANT ADULTS UNDER MEDICAID.

(a) STATE OPTION.—

(1) IN GENERAL.—Section 1903(v)(4)(A) of the Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is amended—

(A) in the matter preceding clause (i)—

(i) by striking ''children and pregnant women'' and inserting ''individuals''; and

(ii) by striking ''either or both'' and inserting ''any or all''; and

(B) by adding at the end the following:

''(iii) OTHER LAWFULLY RESIDING INDIVIDUALS.—Individuals who are not described in clause (i) or (ii).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on January 1, 2014.

(b) CONFORMING AMENDMENT.—Effective as if enacted on October 1, 2009, subparagraph (H) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking ''Paragraph (4) of section 1903(v)'' and inserting ''Clauses (i) and (ii) of section 1903(v)(4)''.

SA 2992. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 867, strike line 15 and all that follows through page 869, line 14, and insert the following:

SEC. 3142. TREATMENT OF URBAN MEDICARE-DEPENDENT HOSPITALS.

Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraph:

''(M) AUTHORIZATION OF ADJUSTMENT IN AMOUNT OF PAYMENT FOR URBAN MEDICARE-DEPENDENT HOSPITALS.—

''(i) STUDY.—The Secretary shall conduct a study on the need for a payment adjustment under the prospective payment system under this section for urban Medicare-dependent hospitals similar to the adjustment available (as of the date of enactment of this subparagraph) to medicare-dependent, small rural hospitals under subparagraph (G). Such study shall compare the Medicare inpatient operating margins of urban Medicare-dependent hospitals to the Medicare inpatient operating margins of subsection (d) hospitals that receive one or more additional payments or adjustments (as defined in clause (iv)). The Secretary shall finish conducting such study by not later than June 1, 2010.

''(ii) AUTHORIZATION OF ADJUSTMENT.—If the Secretary determines under clause (i) that the average Medicare inpatient operating margin of urban Medicare-dependent hospitals is materially lower than the average Medicare inpatient operating margin of subsection (d) hospitals that receive one or more additional payments or adjustments (as so defined), the Secretary shall provide for an adjustment to the payment amounts to urban Medicare-dependent hospitals under this section similar to the adjustment available to medicare-dependent, small rural hospitals under subparagraph (G). Any such adjustment shall be effective for discharges occurring on or after October 1, 2010.

''(iii) DEFINITION OR URBAN MEDICARE-DEPENDENT HOSPITAL.—In this subparagraph, the term 'urban Medicare-dependent hospital' means a subsection (d) hospital—

''(I) located in an urban area;

''(II) that does not receive any additional payments or adjustments (as so defined);

''(III) that is not a physician-owned hospital, as defined in section 489.3 of title 42, Code of Federal Regulations (as in effect as of the date of the enactment of this subparagraph); and

''(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 2006, or 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

''(iv) ADDITIONAL PAYMENTS OR ADJUSTMENTS DEFINED.—The term 'additional payments or adjustments' means payments or adjustments—

''(I) under subparagraph (C) as a rural referral center;

''(II) under subparagraph (D) as a sole community hospital;

''(III) under subparagraph (B) for indirect medical education costs;

''(IV) under subsection (h) for direct graduate medical education costs;

''(V) under subparagraph (F) for disproportionate share hospital payments; or

''(VI) under subparagraph (G) as a medicare-dependent, small rural hospital.''.

SA 2993. Mr. SCHUMER (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 9 through 17 and insert the following:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

''(2) ADJUSTMENT FOR INFLATION.—In the case of a taxable year beginning in any calendar year after 2011, the dollar amount in paragraph (1) shall be increased to the amount equal to such amount as in effect for taxable years beginning in the calendar year preceding such calendar year, increased by an amount equal to the product of—

''(A) such amount as so in effect, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting the calendar year that is 2 years before such calendar year for 'calendar year 1992' in subparagraph (B) thereof, increased by 1 percentage point.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

SA 2994. Mr. SCHUMER (for himself, Mr. AKAKA, Mr. BROWN, Mr. LAUTENBERG, Mr. MERKLEY, Ms. CANTWELL, Mr. KERRY, Mr. LEAHY, Mr. MENENDEZ, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr.

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

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

Subtitle C—Tax Equity for Health Plan Beneficiaries

SEC. 9031. APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.

(a) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986, as amended by section 9003, is amended by adding at the end the following new subsection:

''(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

''(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

''(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'eligible beneficiary' means any individual who is eligible to receive benefits or coverage under an accident or health plan.''.

(b) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''and his dependents'' and inserting ''his dependents'', and

(2) by inserting before the period the following: ''and any eligible beneficiary (within the meaning of section 106(g)) with respect to the taxpayer''.

(c) PAYROLL TAXES.—

(1) Section 3121(a)(2) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'',

(B) by striking ''or any of his dependents,'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(C) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(2) Section 3231(e)(1) of such Code is amended—

(A) by striking ''or any of his dependents'' and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(B) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(3) Section 3306(b)(2) of such Code is amended—

(A) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'',

(B) by striking ''or any of his dependents'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'', and

(C) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(4) Section 3401(a) of such Code is amended by striking ''or'' at the end of paragraph (22), by striking the period at the end of paragraph (23) and inserting ''; or'', and by inserting after paragraph (23) the following new paragraph:

''(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(g).''.

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

SEC. 9032. EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

''(A) the taxpayer,

''(B) the taxpayer's spouse,

''(C) the taxpayer's dependents, and

''(D) any individual who—

''(i) satisfies the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

''(iii) meets the requirements of section 152(d)(1)(C), and

''(E) not more than one individual who—

''(i) does not satisfy the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

''(iii) meets the requirements of section 152(d)(1)(D), and

''(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).''.

(b) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(l)(2) of the Internal Revenue Code of 1986 is amended by inserting '', any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to'' after ''spouse''.

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

SEC. 9033. EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.

(a) IN GENERAL.—Section 501(c)(9) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term 'dependents' shall include any individual who is an eligible beneficiary (within the meaning of section 106(g)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.''.

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

SEC. 9034. FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.

The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's flexible spending arrangement, notwithstanding the fact that such expenses are attributable to any individual who is not the employee's spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's health reimbursement arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the health reimbursement arrangement with respect to the employee.

SA 2995. Mr. SCHUMER (for himself and Ms. MIKULSKI) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 2305. REQUIRING COVERAGE OF SERVICES OF PODIATRISTS.

(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) DELAY IF NEEDED FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SA 2996. Mr. KOHL (for himself, Mr. WYDEN, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed

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

On page 1979, between lines 15 and 16, insert the following:

Subtitle B—Long-Term Care Insurance

PART I—NATIONAL MARKET SURVEY; MODEL DISCLOSURES AND DEFINITIONS; LTC INSURANCE COMPARE

SEC. 8101. NAIC NATIONAL MARKET SURVEY.

(a) IN GENERAL.—The Secretary shall request the NAIC to conduct reviews of the national and State-specific markets for long-term care insurance policies and to submit reports to the Secretary on the results of such reviews every 5 years.

(b) CONTENT.—The Secretary shall request that the reviews include, with respect to the period occurring since any prior review, analysis of the following:

(1) Information on key market parameters, including the number of carriers offering long-term care insurance, and the scope of coverage offered under those policies (such as policies offering nursing-home only benefits, policies offering comprehensive coverage, cash plans, and reimbursement plans, and hybrid products in which long-term care benefits are present).

(2) The number of complaints received and resolved, including benefit denials.

(3) The number of policies that have lapsed.

(4) The number of agents trained and whether the training included competency tests.

(5) The number of policyholders exhausting benefits.

(6) The number of premium rate increases filed by carriers on a policy basis with the States, including the ranges of the increases approved for or finally used.

(7) The number of policyholders affected by any premium rate increases.

(8) Requests for exceptions to State permitted accounting practices, as defined by the NAIC.

(c) TIMING FOR REVIEWS AND REPORTS.—The Secretary shall request the NAIC to—

(1) complete the initial market review under this section not later than 2 years after the date of enactment of this Act;

(2) submit a report to the Secretary on the results of the initial review not later than December 31, 2011; and

(3) complete each subsequent review and submit each subsequent report not later than December 31 of the fifth succeeding year.

(d) CONSULTATION REQUIRED.—The Secretary shall request the NAIC to consult with State insurance commissioners, appropriate Federal agencies, issuers of long-term care insurance, States with experience in long-term care insurance partnership plans, other States, representatives of consumer groups, consumers of long-term care insurance policies, and such other stakeholders as the Secretary or the NAIC determine appropriate, to conduct the market reviews requested under this section.

(e) DEFINITIONS.—In this section and section 8102:

(1) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy''—

(A) means—

(i) a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986); and

(ii) a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section; and

(B) includes any other insurance policy or rider described in the definition of ''long-term care insurance'' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).

(2) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 8102. MODEL DISCLOSURE FORM.

(a) NAIC STUDY AND REPORT ON STATE DISCLOSURE REQUIREMENTS FOR LONG-TERM CARE INSURANCE.—

(1) IN GENERAL.—The Secretary shall request the NAIC to carry out the activities described in paragraph (2) and issue the report described in paragraph (3).

(2) REVIEW AND DEVELOPMENT OF PROPOSED MODEL DISCLOSURE REQUIREMENTS.—The activities described in this paragraph are the following:

(A) MODEL ACT AND REGULATION DISCLOSURE REQUIREMENTS.—Review and describe disclosure requirements for long-term care insurance policies under the Model Act and regulation.

(B) STATE LAW DISCLOSURE REQUIREMENTS.—Review and describe disclosure requirements for long-term care insurance policies under State laws, including as part of such description an analysis of the effectiveness of the various existing disclosures.

(C) LONG-TERM CARE SERVICES.—Review and describe differences in long-term care services, including with respect to providers of such services and the settings in which such services are provided among States and develop standardized definitions for long-term care services.

(D) IDENTIFICATION OF KEY ISSUES FOR DEVELOPMENT OF MODEL DISCLOSURE MARKETING FORM.—Identify and describe key issues to consider in the development of a proposed form for marketing long-term care insurance policies.

(3) REPORT.—The report described in this paragraph is an NAIC White Paper that is issued not later than 12 months after the date of enactment of this Act and contains the results of the reviews conducted under paragraph (2) and the descriptions required under that paragraph.

(b) NAIC WORKING GROUP TO DEVELOP MODEL DISCLOSURE FORM FOR LONG-TERM CARE INSURANCE.—

(1) IN GENERAL.—The Secretary shall request the NAIC to establish, not later than 60 days after the date on which the NAIC White Paper described in subsection (a)(3) is issued and in consultation with the Secretary and the Secretary of the Treasury, a Working Group to develop a model disclosure form for marketing long-term care insurance policies.

(2) WORKING GROUP MEMBERS.—The Working Group established under paragraph (1) shall be composed of the following:

(A) Representatives from State Departments of Health (or the most appropriate State agencies with responsibility for oversight of the provision of long-term care).

(B) Representatives of long-term care providers and facilities.

(C) Consumer advocates.

(D) Representatives of issuers of long-term care insurance policies.

(E) Representatives of the NAIC or State insurance commissioners.

(F) Other experts in long-term care and long-term care insurance policies selected by the Secretary and Secretary of the Treasury or the NAIC.

(3) REQUIREMENTS FOR DEVELOPMENT OF FORM.—

(A) CONSIDERATIONS.—In developing the model form, the Working Group shall consider the following:

(i) Variations among providers, services, and facilities in the long-term care and long-term care insurance markets.

(ii) The results of the reviews and the descriptions included in the NAIC White Paper issued under subsection (a)(3).

(iii) Such other information and factors as the Working Group determines appropriate.

(B) MINIMUM STANDARDS.—The Working Group shall ensure that the model has—

(i) minimum standard definitions for coverage of the various types of services and benefits provided under long-term care insurance policies;

(ii) minimum standard language for use by issuers of such policies, and for agents selling such policies, in explaining the services and benefits covered under the policies and restrictions on the services and benefits;

(iii) minimum standard format, color and type size for disclosure documents; and

(iv) such other minimum standards as the Working Group determines appropriate.

(4) DEADLINE FOR DEVELOPMENT.—The Working Group shall issue a proposed model disclosure form for marketing long-term care insurance policies not later than 1 year after the date on which the Working Group is established.

(5) ADOPTION AND INCORPORATION INTO MODEL ACT AND REGULATION.—The Secretary shall request the NAIC to amend the Model Act and regulation to incorporate the use of the proposed model disclosure form issued by the Working Group, not later than 1 year after the date on which the Working Group issues the form.

(c) REQUIRED USE OF MODEL DISCLOSURE FORM IN MARKETING LONG-TERM CARE INSURANCE POLICIES.—

(1) APPLICATION TO TAX-QUALIFIED AND MEDICAID PARTNERSHIP POLICIES.—Not later than 1 year after the date on which the Working Group issues the proposed model disclosure form for marketing long-term care insurance policies under subsection (b):

(A) TAX-QUALIFIED POLICIES.—The Secretary of the Treasury shall promulgate a regulation requiring, not later than 1 year after the date on which the regulation is final, any issuer of a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986) to use the proposed model disclosure form for marketing such contracts, to the extent such disclosure is not inconsistent with State law.

(B) MEDICAID PARTNERSHIP POLICIES.—The Secretary shall promulgate a regulation requiring, not later than 1 year after the date on which the regulation is final, any issuer that markets a qualified long-term care insurance contract intended to cover an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section to use the proposed model disclosure form for marketing such contracts.

(2) APPLICATION TO ALL OTHER LONG-TERM CARE INSURANCE POLICIES.—Not later than 18 months, or the earliest date on which an amendment could be enacted for those

States with legislatures which meet only every other year, after the date on which the NAIC adopts an amended Model Act and regulation to require the use of the proposed model disclosure form issued by the Working Group under subsection (b), each State shall require by statute or regulation any issuer of a long-term care insurance policy to use the proposed model disclosure form when marketing such a policy in the State.

SEC. 8103. LTC INSURANCE COMPARE.

(a) IN GENERAL.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)—

(i) in clause (ii), by striking ''and'' at the end;

(ii) in clause (iii), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(iv) establish an Internet directory of information regarding long-term care insurance, to be known as 'LTC Insurance Compare', that shall include the following:

''(I) Comparison tools to assist consumers in evaluating long-term care insurance policies (as defined in subparagraph (D)) with different benefits and features and that allow consumers to compare the price, long-term premium stability, and carrier financial strength of such policies.

''(II) State-specific information about the long-term care insurance policies marketed in a State, including the following:

''(aa) Whether a State has promulgated rate stability provisions or has rate stability procedures in place, and how the standards or procedures work.

''(bb) The rating history for at least the most recent preceding 5 years for issuers selling long-term care insurance policies in the State.

''(cc) An appropriate sampling of the policy forms marketed in the State.

''(III) Links to State information regarding long-term care under State Medicaid programs (which may be provided, as appropriate, through Internet linkages to the websites of State Medicaid programs) that includes the following:

''(aa) The medical assistance provided under each State's Medicaid program for nursing facility services and other long-term care services (including any functional criteria imposed for receipt of such services, as reported in accordance with section 1902(a)(28)(D) of the Social Security Act) and any differences from benefits and services offered under long-term care insurance policies in the State and the criteria for triggering receipt of such benefits and services.

''(bb) If the State has a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of the Social Security Act, information regarding how and when an individual with a partnership long-term care insurance policy who is receiving benefits under the policy should apply for medical assistance for nursing facility services or other long-term care services under the State Medicaid program and information regarding about how Medicaid asset protection is accumulated over time.''; and

(B) by adding at the end the following:

''(C) CURRENT INFORMATION.—The Secretary of Health and Human Services shall ensure that, to the greatest extent practicable, the information maintained in the National Clearinghouse for Long-Term Care Information, including the information required for LTC Insurance Compare, is the most recent information available.

''(D) LONG-TERM CARE INSURANCE POLICY DEFINED.—In subparagraph (A)(iv), the term 'long-term care insurance policy' means a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986), a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, and includes any other insurance policy or rider described in the definition of 'long-term care insurance' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).'';

(2) by redesignating paragraph (3) as paragraph (4); and

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

''(3) CONSULTATION ON LTC INSURANCE COMPARE.—The Secretary of Health and Human Services shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in section 8101(d) of the Patient Protection and Affordable Care Act in designing and implementing the LTC Insurance Compare required under paragraph (2)(A)(iv).''.

(b) MEDICAID STATE PLAN REQUIREMENT TO SUBMIT NURSING FACILITY SERVICES FUNCTIONAL CRITERIA DATA.—Section 1902(a)(28) of the Social Security Act (42 U.S.C. 1396a(a)(28)) is amended—

(1) in subparagraph (C), by striking ''and'' after the semicolon;

(2) in subparagraph (D)(iii), by adding ''and'' after the semicolon; and

(3) by inserting after subparagraph (D)(iii), the following new subparagraph:

''(E) for the annual submission of data relating to functional criteria for the receipt of nursing facility services under the plan (in such form and manner as the Secretary shall specify);''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation or State regulation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional 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 Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

PART II—IMPROVED STATE CONSUMER PROTECTIONS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS AND MEDICAID PARTNERSHIP POLICIES

SEC. 8121. APPLICATION OF MEDICAID PARTNERSHIP REQUIRED MODEL PROVISIONS TO ALL TAX-QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Section 7702B(g)(1) of the Internal Revenue Code of 1986 (relating to consumer protection provisions) is amended—

(1) in subparagraph (A), by inserting ''(but only to the extent such requirements do not conflict with requirements applicable under subparagraph (B)),'' after ''paragraph (2)'',

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

(3) by inserting after subparagraph (A), the following new subparagraph:

''(B) the requirements of the model regulation and model Act described in section 1917(b)(5) of the Social Security Act,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contracts issued on or after the date that is 1 year after the date of enactment of this Act.

SEC. 8122. STREAMLINED PROCESS FOR APPLYING NEW OR UPDATED MODEL PROVISIONS.

(a) SECRETARIAL REVIEW.—

(1) TAX-QUALIFIED POLICIES.—

(A) 2000 AND 2006 MODEL PROVISIONS.—Not later than 12 months after the date of enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions specified in subsection (c)(1) for purposes of determining whether updating any such provisions for a provision specified in section 7702B(g)(2) of the Internal Revenue Code of 1986, or the inclusion of any such provisions in such section, for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under such Code, would improve consumer protections for insured individuals under such contracts.

(B) SUBSEQUENT MODEL PROVISIONS.—Not later than 12 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of qualifying for treatment as a qualified long-term care insurance contract under section 7702B(g)(2) of the Internal Revenue Code of 1986, would improve consumer protections for insured individuals under such contracts.

(2) MEDICAID PARTNERSHIP POLICIES.—

(A) SUBSEQUENT MODEL PROVISIONS.—Not later than 12 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)) would improve consumer protections for insured individuals under such contracts.

(B) REVIEW OF OTHER PARTNERSHIP REQUIREMENTS.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review clauses (iii) and (iv) of section 1917(b)(1)(C) for purposes of determining whether the requirements specified in such clauses should be modified to provide improved consumer protections or, as appropriate, to resolve any conflicts with the application of the 2006 model provisions under paragraph (5) of section 1917(b) (as amended by section 302(a)) or with the application of any model provisions that the Secretary determines should apply to an insurance contract as a result of a review required under subparagraph (A).

(b) EXPEDITED RULEMAKING.—

(1) TAX-QUALIFIED POLICIES.—Subject to paragraph (3), if the Secretary of the Treasury determines that any model provisions reviewed under subsection (a)(1) should apply

for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under the Internal Revenue Code of 1986, the Secretary shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(2) MEDICAID PARTNERSHIP POLICIES.—Subject to paragraph (3), if the Secretary of Health and Human Services determines that any model provisions or requirements reviewed under subsection (a)(2) should apply for purposes of an insurance contract satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)), the Secretary shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(3) CONSULTATION REQUIRED.—The Secretary of the Treasury and the Secretary of Health and Human Services, respectively, shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in section 101(d) regarding the extent to which it is appropriate to apply the model provisions described in paragraph (1) or (2) (as applicable) to insurance contracts described in such paragraphs through promulgation of an interim final rule. If, after such consultation—

(A) the Secretary of the Treasury determines it would be appropriate to promulgate an interim final rule, the Secretary of the Treasury shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (1); and

(B) the Secretary of Health and Human Services determines it would be appropriate to promulgate an interim final rule, the Secretary of Health and Human Services shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (2).

(4) RULE OF CONSTRUCTION RELATING TO APPLICATION OF CONGRESSIONAL REVIEW ACT.—Nothing in paragraphs (1), (2), or (3) shall be construed as affecting the application of the sections 801 through 808 of title 5, United States Code (commonly known as the ''Congressional Review Act'') to any interim final rule issued in accordance with such paragraphs.

(5) TECHNICAL AMENDMENT ELIMINATING PRIOR REVIEW STANDARD MADE OBSOLETE.—Section 1917(b)(5) of the Social Security Act (42 U.S.C. 1396p(b)(5)) is amended by striking subparagraph (C).

(c) MODEL PROVISIONS.—In this section, the term ''model provisions'' means—

(1) each provision of the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000 and as of December 2006);

(2) each provision of the model language relating to marketing disclosures and definitions developed under section 102(b)(1); and

(3) each provision of any long-term care insurance model regulation, or the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners and adopted after December 2006.

PART III—IMPROVED CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIP POLICIES

SEC. 8131. BIENNIAL REPORTS ON IMPACT OF MEDICAID LONG-TERM CARE INSURANCE PARTNERSHIPS.

Section 6021(c) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended to read as follows:

''(c) BIENNIAL REPORTS.—

''(1) IN GENERAL.—Not later than January 1, 2011, and biennially thereafter, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall issue a report to States and Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)). Each report shall include (with respect to the period the report addresses) the following information, nationally and on a State-specific basis:

''(A) Analyses of the extent to which such partnerships improve access of individuals to affordable long-term care services and benefits and the impact of such partnerships on Federal and State expenditures on long-term care under the Medicare and Medicaid programs.

''(B) Analyses of the impact of such partnerships on consumer decisionmaking with respect to purchasing, accessing, and retaining coverage under long-term care insurance policies (as defined in subsection (d)(2)(D)), including a description of the benefits and services offered under such policies, the average premiums for coverage under such policies, the number of policies sold and at what ages, the number of policies retained and for how long, the number of policies for which coverage was exhausted, and the number of insured individuals who were determined eligible for medical assistance under the State Medicaid program.

''(2) DATA.—The reports by issuers of partnership long-term care insurance policies required under section 1917(b)(1)(C)(iii)(VI) of the Social Security Act shall include such data as the Secretary shall specify in order to conduct the analyses required under paragraph (1).

''(3) PUBLIC AVAILABILITY.—The Secretary shall make each report issued under this subsection publicly available through the LTC Insurance Compare website required under subsection (d).

''(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.''.

SEC. 8132. ADDITIONAL CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIPS.

(a) APPLICATION OF 2006 MODEL PROVISIONS.—

(1) UPDATING OF 2000 REQUIREMENTS.—

(A) IN GENERAL.—Section 1917(b)(5)(B)(i) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(i)) is amended by striking ''October 2000'' and inserting ''December 2006''.

(B) CONFORMING AMENDMENTS.—

(i) Subclause (XVII) of such section is amended by striking ''section 26'' and inserting ''section 28''.

(ii) Subclause (XVIII) of such section is amended by striking ''section 29'' and inserting ''section 31''.

(iii) Subclause (XIX) of such section is amended by striking ''section 30'' and inserting ''section 32''.

(2) APPLICATION TO GRANDFATHERED PARTNERSHIPS.—Section 1917(b)(1)(C)(iv) of such Act (42 U.S.C. 1396p(b)(1)(C)(iv)) is amended by inserting '', and the State satisfies the requirements of paragraph (5)'' after ''2005''.

(b) APPLICATION OF PRODUCER TRAINING MODEL ACT REQUIREMENTS.—Section 1917(b)(1)(C) of such Act (42 U.S.C. 1396p(b)(1)(C)) is amended—

(1) in clause (iii)(V), by inserting ''and satisfies the producer training requirements specified in section 9 of the model Act specified in paragraph (5)'' after ''coverage of long-term care''; and

(2) in clause (iv), as amended by subsection (a)(2), by inserting ''clause (iii)(V) and'' before ''paragraph (5)''.

(c) APPLICATION OF ADDITIONAL REQUIREMENTS FOR ALL PARTNERSHIPS.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1)(C)—

(A) in clause (iii)—

(i) by inserting after subclause (VII) the following new subclause:

''(VIII) The State satisfies the requirements of paragraph (6).''; and

(ii) in the flush sentence at the end, by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

(B) in clause (iv), as amended by subsections (a)(2) and (b)(2), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

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

''(6) For purposes of clauses (iii)(VIII) and (iv) of paragraph (1)(C), the requirements of this paragraph are the following:

''(A) The State requires issuers of long-term care insurance policies to—

''(i) use marketing materials filed with the State for purposes of the partnership in all sales and marketing activities conducted or supported by the issuers in the State with respect to any long-term care insurance policies marketed by the issuer in the State;

''(ii) provide such materials to all agents selling long-term care insurance policies in the State;

''(iii) ensure that agent training and education courses conducted or supported by the issuers incorporate discussion of marketing materials; and

''(iv) make such materials available to any consumer upon request, and to make such materials available to all prospective purchasers of a policy offered under a qualified State long-term care insurance partnership before submission of an application for coverage under that policy.

''(B) The State requires issuers of long-term care insurance policies sold in the State to require agents to use any inflation protection comparison form developed by the National Association of Insurance Commissioners when selling the policies in the State.

''(C) The State requires issuers of long-term care insurance policies sold in the State to comply with the provisions of section 8 of the model Act specified in paragraph (5) relating to contingent nonforfeiture benefits.

''(D) The State enacts legislation, not later than January 1, 2012, that establishes rating standards for all issuers of long-term care insurance policies sold in the State that result in rates over the life of the policy that are no less protective of consumers than those produced by the premium rate schedule increase standards specified in section 20 of the model regulation specified in paragraph (5), unless the State has more stringent procedures or requirements.

''(E) The State develops and updates marketing materials filed with the State whenever changes are made under the State plan that relate to eligibility for medical assistance for nursing facility services, including other long-term care services or the amount, duration, or scope of medical assistance for nursing facility services, and also provides to

individuals at the time of application for medical assistance under the State plan, or under a waiver of the plan materials that describe in clear, simple language the terms of eligibility, the benefits and services provided as such assistance, and rules relating to adjustment or recovery from the estate of an individual who receives such assistance. Such materials shall include a clear disclosure that medical assistance is not guaranteed to partnership policyholders who exhaust benefits under a partnership policy, and that Federal changes to the program under this title or State changes to the State plan may affect an individual's eligibility for, or receipt of, such assistance.

''(F) The State—

''(i) through the State Medicaid agency under section 1902(a)(5) and in consultation with the State insurance department, develops materials explaining how the benefits and rules of long-term care policies offered by issuers participating in the partnership interact with the benefits and rules under the State plan under this title;

''(ii) requires agents to use such materials when selling or otherwise discussing how long-term care policies offered by issuers participating in the partnership work with potential purchasers and to provide the materials to any such purchasers upon request;

''(iii) informs holders of such policies of any changes in eligibility requirements under the State plan under this title and of any changes in estate recovery rules under the State plan as soon as practicable after such changes are made at the time or at the time of application for medical assistance; and

''(iv) agrees to honor the asset protections of any such policy that were provided under the policy when purchased, regardless of whether the State subsequently terminates a partnership program under the State plan.

''(G) The State Medicaid agency under section 1902(a)(5) and the State insurance department enter into a memorandum of understanding to—

''(i) inform consumers about long-term care policies offered by issuers participating in the partnership, the amount, duration, or scope of medical assistance for nursing facility services or other long-term care services offered under the State plan, consumer protections, and any other issues such agency and department determine appropriate through such means as the State determines appropriate; and

''(ii) jointly facilitate coordination in eligibility determinations for medical assistance under the State plan and the provision of benefits or other services under such policies and medical assistance provided under the State plan that includes—

''(I) the number of policyholders applying for medical assistance under the State plan; and

''(II) the number of policyholders deemed eligible (and, if applicable, ineligible) for such assistance.

''(H) Subject to subparagraph (I), the State enters into agreements with other States that have established qualified State long-term care insurance partnerships under which such States agree to provide reciprocity for policyholders under such partnerships, including providing guaranteed asset protection to all individuals covered under a policy offered under a qualified State long-term care insurance partnership who bought such a policy in the State or in another State with such a partnership and with which the State has a reciprocity agreement.

''(I)(i) In the case of a State described in paragraph (1)(C)(iv) (in this subparagraph referred to as a 'grandfathered partnership State') —

''(I) the grandfathered partnership State may, in lieu of entering into agreements that satisfy subparagraph (I), enter into individual reciprocity agreements with other States that have established qualified State long-term care insurance partnerships; and

''(II) if the grandfathered partnership State has not, as of January 1, 2013, entered into a reciprocity agreement with each State that has a qualified State long-term care insurance partnership, the grandfathered partnership State shall enter into and comply with a reciprocity agreement developed by the Secretary in accordance with clause (ii) for each partnership State that the grandfathered State does not have a reciprocity agreement with and, with respect to each such State, for so long as the grandfathered partnership State does not have an individual reciprocity agreement with that State.

''(ii) In developing a reciprocity agreement for purposes of clause (i)(II), the Secretary shall take into account—

''(I) the difference in consumer protections under the partnership program of the grandfathered partnership State and the other partnership State that will be covered by the agreement, and, to the greatest extent possible, preserve the more protective requirements; and

''(II) the impact the reciprocity agreement will have on expenditures under the State plan under this title (including under any waivers of such plan) of each such State and, to the greatest extent possible, minimize any negative impact on such expenditures and States.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date that is 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional 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 Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 8133. REPORT TO CONGRESS REGARDING NEED FOR MINIMUM ANNUAL COMPOUND INFLATION PROTECTION.

Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit a report to Congress that includes the Secretary's recommendation regarding whether legislative or other administrative action should be taken to require all long-term care insurance policies sold after a date determined by the Secretary in connection with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, provide a minimum level of annual compound inflation protection, and if so, whether such requirements should be imposed on a basis related to the age of the policyholder at the time of purchase. The Secretary shall include in the report information on the various levels of inflation protection available under such long-term care insurance partnerships and the methodologies used by issuers of such policies to calculate and present various inflation protection options under such policies, including policies with a future purchase option feature.

PART IV—PRESERVATION OF STATE AUTHORITY

SEC. 8141. PRESERVATION OF STATE AUTHORITY.

Nothing in this title, any amendments made by this title, or any rules promulgated to carry out this title or such amendments, shall be construed to limit the authority of a State to enact, adopt, promulgate, and enforce any law, rule, regulation, or other measure with respect to long-term care insurance that is in addition to, or more stringent than, requirements established under this title and the amendments made by this title.

SA 2997. Ms. KLOBUCHAR (for herself, Mr. BROWN, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1441, line 5, strike ''or pediatric medicine'' and insert ''neurology, or pediatric medicine''.

SA 2998. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. PROVIDER AND SUPPLIER PAYMENTS UNDER MEDICARE AND MEDICAID THROUGH DIRECT DEPOSIT OR ELECTRONIC FUNDS TRANSFER (EFT) AT INSURED DEPOSITORY INSTITUTIONS.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(i) LIMITATION ON PAYMENT TO PROVIDERS OF SERVICES AND SUPPLIERS.—No payment shall be made under this title for items and services furnished by a provider of services or supplier unless each payment to the provider of services or supplier is in the form of direct deposit or electronic funds transfer to the provider of services' or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A))).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to each payment made to a provider of services, provider, or supplier on or after such date (not later than July 1, 2012) as the Secretary of

Health and Human Services shall specify, regardless of when the items and services for which such payment is made were furnished.

(b) MEDICAID PILOT PROJECT.—

(1) AUTHORITY TO ESTABLISH.—The Secretary shall establish a Medicaid pilot project under which payment for items and services furnished by providers or suppliers of items or services under the Medicaid programs of the States selected to participate in the project is in the form of a direct deposit or electronic funds transfer to the provider's or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A))).

(2) DEADLINE FOR IMPLEMENTATION.—The pilot project established under paragraph (1) shall begin in fiscal year 2012.

(3) REPORT.—Not later than September 30, 2014, the Secretary of Health and Human Services shall report to Congress on the pilot project established under this subsection. The report shall include an analysis of the extent to which the project is effective in improving efficiency, reducing administrative costs, and preventing fraud in the Medicaid program and a recommendation as to whether the project should be expanded to additional or all State Medicaid programs.

SA 2999. Ms. SNOWE (for herself, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2057, between lines 6 and 7, insert the following:

SEC. ___. APPLICATION OF CAFETERIA PLANS TO SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—

(1) APPLICATION TO SELF-EMPLOYED INDIVIDUALS.—Section 125(d) of the Internal Revenue Code of 1986 (defining cafeteria plan) is amended by adding at the end the following new paragraph:

''(3) EMPLOYEE TO INCLUDE SELF-EMPLOYED.—

''(A) IN GENERAL.—The term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(B) LIMITATIONS.—

''(i) IN GENERAL.—The amount which may be excluded under subsection (a) with respect to a participant in a cafeteria plan by reason of being an employee under subparagraph (A) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the cafeteria plan is established.

''(ii) LIMITATIONS ON CERTAIN FLEXIBLE SPENDING ARRANGEMENTS.—No amount shall be excluded under subsection (a) with respect to any plan which provides benefits in the form of a health flexible spending arrangement or a dependent care flexible spending arrangement and in which an individual described in subparagraph (A) participates unless such plan is administered by a person other than the employer.

''(C) ADDITIONAL TAX ON UNREIMBURSED AMOUNTS.—

''(i) IN GENERAL.—The tax imposed by this chapter on any person who is described in subparagraph (A) and who is a participant in a cafeteria plan which provides benefits in the form of a health flexible spending arrangement or a dependent care flexible spending arrangement shall be increased by an amount equal to 100 percent of the excess (if any) of—

''(I) the maximum value of the qualified benefit with respect to such person, over

''(II) the amount of covered expenses both incurred during the coverage period for the qualified benefit, and any grace period, and reimbursed during that period or during any appropriate run-out period.

''(ii) COLLECTION.—The tax imposed by this subparagraph shall be collected by the person administering the flexible spending arrangement, and to the extent that such person fails to collect such tax, the tax shall be paid by such person.''.

(2) APPLICATION TO BENEFITS WHICH MAY BE PROVIDED UNDER CAFETERIA PLAN.—

(A) GROUP-TERM LIFE INSURANCE.—Section 79 of the Internal Revenue Code of 1986 (relating to group-term life insurance provided to employees) is amended by adding at the end the following new subsection:

''(f) EMPLOYEE INCLUDES SELF-EMPLOYED.—

''(1) IN GENERAL.—For purposes of this section, the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under the exceptions contained in subsection (a) or (b) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the individual is so treated.''.

(B) ACCIDENT AND HEALTH PLANS.—Subsection (g) of section 105 of such Code (relating to amounts received under accident and health plans) is amended to read as follows:

''(g) EMPLOYEE INCLUDES SELF-EMPLOYED.—

''(1) IN GENERAL.—For purposes of this section, in the case of any coverage under an accident or health plan which is provided through a simple cafeteria plan under section 125(j), the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under this section by reason of subsection (b) or (c) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the accident or health insurance was established.''.

(C) CONTRIBUTIONS BY EMPLOYERS TO ACCIDENT AND HEALTH PLANS.—

(i) IN GENERAL.—Section 106 of such Code is amended by inserting after subsection (e) the following new subsection:

''(f) SPECIAL RULE FOR BENEFITS PROVIDED THROUGH SIMPLE CAFETERIA PLANS.—

''(1) IN GENERAL.—For purposes of this section, in the case of any coverage under an accident or health plan which is provided through a simple cafeteria plan under section 125(j), the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under subsection (a) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the accident or health insurance was established.''.

(ii) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

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

SA 3000. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title VI insert the following:

SEC. 6303. PROHIBITION ON COMPARATIVE EFFECTIVENESS RESEARCH FOR THE PURPOSE OF DETERMINING COST AND COVERAGE DECISIONS.

Reports and recommendations from the Patient-Centered Outcomes Research Institute, established under section 1181 of the Social Security Act (as added by section 6301), or any other government entity are prohibited from being used by any government entity for payment, coverage, or treatment decisions based on costs. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of such Institute or other government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Wednesday, December 9, 2009, at 9:30 a.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed immediately by a legislative hearing on S. 1690, a bill to amend the Act of March 1, 1933, to transfer certain authority and resources to the Utah Dineh Corporation, and for other purposes. The Committee will then conduct a hearing entitled ''Where's the Trustee? U.S. Department of the Interior Backlogs Prevent Tribes from Using their Lands.''

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

EXECUTIVE SESSION

NOMINATIONS DISCHARGED

Mr. BROWN. Madam President, I ask unanimous consent the Senate proceed to executive session and the Foreign Relations Committee be discharged en bloc from PN1001, PN1002, PN1003, PN1005, PN1016; and then the Senate