Industries Transparency Initiative, and for other purposes; to the Committee on Foreign Relations.

By Mr. TESTER (for himself and Mr. ROBERTS):

S. 956. A bill to amend title XVIII of the Social Security Act to exempt unsanctioned State-licensed retail pharmacies from the surety bond requirement under the Medicare Program for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); to the Committee on Finance.

By Mr. DURBIN (for himself, Mr. BINGAMAN, Mr. CASEY, and Mr. FEINGOLD):

S. 957. A bill to amend the Public Health Service Act to ensure that victims of public health emergencies have meaningful and immediate access to medically necessary health care services; to the Committee on Health, Education, Labor, and Pensions.

By Mr. ROCKEFELLER (for himself, Mr. CASEY, and Mrs. GILLIBRAND):

S. 958. A bill to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2009; to the Committee on Finance.

By Mr. ROCKEFELLER:

S. 959. A bill to provide for the extension of a certain hydroelectric project located in the State of West Virginia; to the Committee on Energy and Natural Resources.

By Mr. ROCKEFELLER (for himself, Mr. BROWN, and Mr. CARDIN):

S. 960. A bill to amend title XVIII of the Social Security Act and the Employee Retirement Income Security Act of 1974 to provide access to Medicare benefits for individuals ages 55 to 65, to amend the Internal Revenue Code of 1986 to allow a refundable and advanceable credit against income tax for payment of such premiums, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LAUTENBERG (for himself, Mr. ROCKEFELLER, Mrs. HUTCHISON, Mr. THUNE, Mr. DORGAN, Mrs. BOXER, Mr. WHITEHOUSE, Mr. WARNER, Mr. KERRY, Mr. DURBIN, Mr. SPECTER, Mr. SCHUMER, Mr. BAYH, Mr. UDALL of New Mexico, Mr. BROWN, Mr. CARPER, and Mr. LIEBERMAN):

S. Res. 125. A resolution in support and recognition of National Train Day, May 9, 2009; to the Committee on Commerce, Science, and Transportation.

ADDITIONAL COSPONSORS

S. 540

At the request of Mr. KENNEDY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 540, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to liability under State and local requirements respecting devices.

S. 614

At the request of Mrs. HUTCHISON, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 614, a bill to award a Congressional Gold Medal to the Women Airforce Service Pilots (''WASP'').

S. 645

At the request of Mrs. LINCOLN, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 645, a bill to amend title 32, United States Code, to modify the Department of Defense share of expenses under the National Guard Youth Challenge Program.

S. 738

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 738, a bill to amend the Consumer Credit Protection Act to assure meaningful disclosures of the terms of rental-purchase agreements, including disclosures of all costs to consumers under such agreements, to provide certain substantive rights to consumers under such agreements, and for other purposes.

S. 790

At the request of Mr. BINGAMAN, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 790, a bill to improve access to health care services in rural, frontier, and urban underserved areas in the United States by addressing the supply of health professionals and the distribution of health professionals to areas of need.

S. 909

At the request of Mr. KENNEDY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 909, a bill to provide Federal assistance to States, local jurisdictions, and Indian tribes to prosecute hate crimes, and for other purposes.

S. 944

At the request of Mr. FEINGOLD, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 944, a bill to amend title 10, United States Code, to require the Secretaries of the military departments to give wounded members of the reserve components of the Armed Forces the option of remaining on active duty during the transition process in order to continue to receive military pay and allowances, to authorize members to reside at their permanent places of residence during the process, and for other purposes.

S. 949

At the request of Mr. BINGAMAN, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 949, a bill to improve the loan guarantee program of the Department of Energy under title XVII of the Energy Policy Act of 2005, to provide additional options for deploying energy technologies, and for other purposes.

S. CON. RES. 16

At the request of Mr. MCCAIN, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. Con. Res. 16, a concurrent resolution expressing the sense of the Senate that the President of the United States should exercise his constitutional authority to pardon posthumously John Arthur ''Jack'' Johnson for the racially motivated conviction in 1913 that diminished the athletic, cultural, and historic significance of Jack Johnson and unduly tarnished his reputation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. SNOWE (for herself, Mr. NELSON of Florida, Ms. CANTWELL, Mr. LEVIN, Mr. VITTER, Mr. CARDIN, Ms. LANDRIEU, and Mrs. BOXER):

S. 952. A bill to develop and promote a compressive plan for a national strategy to address harmful algal blooms and hypoxia through baseline research, forecasting and monitoring, and mitigation and control while helping communities detect, control, and mitigate coastal and Great Lakes harmful algal blooms and hypoxia events; to the Committee on Commerce, Science, and Transportation.

Ms. SNOWE. Mr. President, I rise today to introduce the Harmful Algal Blooms and Hypoxia Research and Control Amendments Act of 2009. This bill would enhance the research programs established in the Harmful Algal Blooms and Hypoxia Research and Control Act of 1998 and reauthorized in 2004, which have greatly enhanced our ability to predict outbreaks of harmful algal blooms and the extent of hypoxic zones. But knowing when outbreaks will occur is only half the battle. By funding additional research into mitigation and prevention of HABs and hypoxia, and by enabling communities to develop response strategies to more effectively reduce their effects on our coastal communities, this legislation would take the next critical steps to reducing the social and economic impacts of these potentially disastrous outbreaks.

I am proud to continue my leadership on this important issue and I particularly want to thank my counterpart on this key piece of legislation, Senator BILL NELSON. My partnership with Senator Breaux on the first two harmful algal bloom bills proved extremely fruitful, and I am pleased that Gulf of Mexico—whose coastal residents are severely impacted by both harmful algal blooms, also known as HABs, and hypoxia—will continue to be so well represented as this program moves into the future. I also want to thank the bill's additional co-sponsors, Senators CANTWELL, CARDIN, VITTER, LANDRIEU, BOXER and LEVIN for their vital contributions. We all represent coastal States directly affected by harmful algal blooms and hypoxia, and we see first hand the ecological and economic damage caused by these events.

In New England blooms of Alexandrium algae, more commonly known as ''red tide'' can cause shellfish to accumulate toxins that when consumed by humans lead to paralytic shellfish poisoning, PSP, a potentially fatal neurological disorder. Therefore, when levels of Alexandrium reach dangerous levels, our fishery managers are

forced to close shellfish beds that provide hundreds of jobs and add millions of dollars to our regional economy. Red tide outbreaks—which occur in various forms not just in the northeast, but along thousands of miles of U.S. coastline—have increased dramatically in the Gulf of Maine in the last 20 years, with major blooms occurring almost every year.

In 2005, the most severe red tide since 1972 blanketed the New England coast from Martha's Vineyard to Downeast Maine, resulting in extensive commercial and recreational shellfish harvesting closures lasting several months at the peak of the seafood harvesting season. In a peer-reviewed study, economists found that the 2005 event caused over $4.9 million in lost landings of shellfish in the State of Maine alone, and more than $20 million throughout New England.

Last year's outbreak of red tide tracked very closely the patter of the 2005 event in both location and severity, but unlike in 2005 when nearly the entire coasts of Maine and Massachusetts were closed, resource managers had improved testing capabilities in place that allowed many localized areas to remain open. Such procedures were a direct result of programs established by the Harmful Algal Blooms and Hypoxia Research and Control Acts of 1998 and 2004.

Most recently, on April 22, 2009 researchers at Woods Hole Oceanographic Institution and North Carolina State University announced the potential for ''red tide'' in the Gulf of Maine this season is expected to be ''moderately large'', based on a regional seafloor survey of Alexandrium abundance. This survey revealed that levels of Alexandrium are currently higher than those observed just prior to the 2005 red tide. Just a few days ago, officials from the Maine Department of Resources Marine Biotoxin Monitoring Program closed a large parcel of the Maine coast to the harvest of mussels, oysters, and carnivorous snails due to the presence of PSP. The current trend of increasing frequency and intensity of red tide events in new England waters is just one example of the need to further enhance our ability to provide detailed forecasting and testing measures. The quick response time these capabilities enable will greatly reduce the economic impact such outbreaks impose on our coastal communities.

While we have made great strides in bloom prediction and monitoring, it is clear that these problems have not gone away, but rather increased in magnitude. Harmful algal blooms remain prevalent nationwide, and areas of hypoxia, also known as ''dead zones'' are now occurring with increasing frequency. Within a dead zone, oxygen levels plummet to the point at which they can no longer sustain life, driving out animals that can move, and killing those that cannot. The most infamous dead zone occurs annually in the Gulf of Mexico, off the shores of Louisiana. In 2008, researchers determined that this dead zone extended over 12,875 square miles, making it the second largest since measurements began in 1985. Dead zones are also occurring with increasing frequency in more areas than ever before, including off the coasts of Oregon, the Chesapeake Bay and Texas.

The amendments contained in this legislation would enhance the Nation's ability to predict, monitor, and ultimately control harmful algal blooms and hypoxia. Understanding when these blooms will occur is vital, but the time has come to take this program to the next level—to determine not just when an outbreak will occur, but how to reduce its intensity or prevent its occurrence all together. This bill would build on NOAA's successes in research and forecasting by creating a program to mitigate and control HAB outbreaks.

This bill also recognizes the need to enhance coordination among state and local resource managers—those on the front lines who must make the decisions to close beaches or shellfish beds. Their decisions are critical to protecting human health, but can also impose significant economic impacts. The bill would mandate creation of Regional Research and Action Plans that would identify baseline research, possible State and local government actions to prepare for and mitigate the impacts of HABs, and establish outreach strategies to ensure the public is informed of the dangers these events can present. A regional focus on these issues will ensure a more effective and efficient response to future events. And finally, this bill would, for the first time, create a pilot program to examine harmful algal blooms and hypoxia in fresh water systems.

If enacted, this critical reauthorization would greatly enhance our Nation's ability to predict, monitor, mitigate, and control outbreaks of HABs and hypoxia. Over half the U.S. population resides in coastal regions, and we must do all in our power to safeguard their health and the health of the marine environment. The existing Harmful Algal Bloom and Hypoxia Program has done a laudable job to date, and this authorization will allow them to expand their scope and provide greater benefits to the Nation as a whole. I thank Senator Bill Nelson, and all of my cosponsors again for their efforts in developing this vital legislation.

Mr. President, I ask unamimous consent that the text of the bill be printed in the RECORD.

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

S. 952

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Harmful Algal Blooms and Hypoxia Research and Control Amendments Act of 2009''.

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

SEC. 2. AMENDMENT OF HARMFUL ALGAL BLOOM AND HYPOXIA RESEARCH AND CONTROL ACT OF 1998.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Harmful Algal Bloom and Hypoxia Research and Control Act of 1998 (16 U.S.C. 1451 note).

SEC. 3. FINDINGS.

Section 602 is amended to read as follows:

''SEC. 602. FINDINGS.

The Congress finds the following:

''(1) Harmful algal blooms and hypoxia are increasing in frequency and intensity in the Nation's coastal waters and Great Lakes and pose a threat to the health of coastal and Great Lakes ecosystems, are costly to coastal economies, and threaten the safety of seafood and human health.

''(2) Excessive nutrients in coastal waters have been linked to the increased intensity and frequency of hypoxia and some harmful algal blooms and there is a need to identify more workable and effective actions to reduce the negative impacts of harmful algal blooms and hypoxia on coastal waters.

''(3) The National Oceanic and Atmospheric Administration, through its ongoing research, monitoring, observing, education, grant, and coastal resource management programs and in collaboration with the other Federal agencies, on the Interagency Task Force, along with States, Indian tribes, and local governments, possesses a full range of capabilities necessary to support a near and long-term comprehensive effort to prevent, reduce, and control the human and environmental costs of harmful algal blooms and hypoxia.

''(4) Harmful algal blooms and hypoxia can be triggered and exacerbated by increases in nutrient loading from point and non-point sources, much of which originates in upland areas and is delivered to marine and freshwater bodies via river discharge, thereby requiring integrated and landscape-level research and control strategies.

''(5) Harmful algal blooms and hypoxia affect many sectors of the coastal economy, including tourism, public health, and recreational and commercial fisheries; and according to a recent report produced by NOAA, the United States seafood and tourism industries suffer annual losses of $82 million due to economic impacts of harmful algal blooms.

''(6) Global climate change and its effect on oceans and the Great Lakes may ultimately play a role in the increase or decrease of harmful algal bloom and hypoxic events.

''(7) Proliferations of harmful and nuisance algae can occur in all United States waters, including coastal areas and estuaries, the Great Lakes, and inland waterways, crossing political boundaries and necessitating regional coordination for research, monitoring, mitigation, response, and prevention efforts.

''(8) Following passage of the Harmful Algal Bloom and Hypoxia Research and Control Act of 1998, Federally-funded and other research has led to several technological advances, including remote sensing, molecular and optical tools, satellite imagery, and coastal and ocean observing systems, that provide data for forecast models, improve the monitoring and prediction of these events, and provide essential decision making tools for managers and stakeholders.''.

SEC. 4. PURPOSE.

The Act is amended by inserting after section 602 the following:

''SEC. 602A. PURPOSES.

''The purposes of this Act are—

''(1) to provide for the development and coordination of a comprehensive and integrated national program to address harmful algal blooms and hypoxia through baseline research, monitoring, prevention, mitigation, and control;

''(2) to provide for the assessment of environmental, socio-economic, and human health impacts of harmful algal blooms and hypoxia on a regional and national scale, and to integrate that assessment into marine and freshwater resource decisions; and

''(3) to facilitate regional, State, and local efforts to develop and implement appropriate harmful algal bloom and hypoxia response plans, strategies, and tools including outreach programs and information dissemination mechanisms.''.

SEC. 5. INTERAGENCY TASK FORCE ON HARMFUL ALGAL BLOOMS AND HYPOXIA.

(a) FEDERAL REPRESENTATIVES.—Section 603(a) is amended—

(1) by striking ''The Task Force shall consist of the following representatives from—'' and inserting ''The Task Force shall consist of representatives of the Office of the Secretary from each of the following departments and of the office of the head of each of the following Federal agencies:'';

(2) by striking ''the'' in paragraphs (1) through (11) and inserting ''The'';

(3) by striking the semicolon in paragraphs (1) through (10) and inserting a period.

(4) by striking ''Quality; and'' in paragraph (11) and inserting ''Quality.''; and

(5) by striking ''such other'' in paragraph (12) and inserting ''Other''.

(b) STATE REPRESENTATIVES.—Section 603 is amended—

(1) by striking subsections (b) through (i); and

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

''(b) STATE REPRESENTATIVES.—The Secretary shall establish criteria for determining appropriate States to serve on the Task Force and establish and implement a nominations process to select representatives from 2 appropriate States in different regions, on a rotating basis, to serve 2-year terms on the Task Force.''.

SEC. 6. NATIONAL HARMFUL ALGAL BLOOM AND HYPOXIA PROGRAM.

The Act is amended by inserting after section 603 the following:

''SEC. 603A. NATIONAL HARMFUL ALGAL BLOOM AND HYPOXIA PROGRAM.

''(a) ESTABLISHMENT.—The President, acting through NOAA, shall establish and maintain a national program for integrating efforts to address harmful algal bloom and hypoxia research, monitoring, prediction, control, mitigation, prevention, and outreach.

''(b) TASK FORCE FUNCTIONS.—The Task Force shall be the oversight body for the development and implementation of the national harmful algal bloom and hypoxia program and shall—

''(1) coordinate interagency review of plans and policies of the Program;

''(2) assess interagency work and spending plans for implementing the activities of the Program;

''(3) review the Program's distribution of Federal grants and funding to address research priorities;

''(4) support implementation of the actions and strategies identified in the regional research and action plans under subsection (d);

''(5) support the development of institutional mechanisms and financial instruments to further the goals of the program;

''(6) expedite the interagency review process and ensure timely review and dispersal of required reports and assessments under this Act; and

''(7) promote the development of new technologies for predicting, monitoring, and mitigating harmful algal blooms and hypoxia conditions.

''(c) LEAD FEDERAL AGENCY.—NOAA shall be the lead Federal agency for implementing and administering the National Harmful Algal Bloom and Hypoxia Program.

''(d) RESPONSIBILITIES.—The Program shall—

''(1) promote a national strategy to help communities understand, detect, predict, control, and mitigate freshwater and marine harmful algal bloom and hypoxia events;

''(2) plan, coordinate, and implement the National Harmful Algal Bloom and Hypoxia Program; and

''(3) report to the Task Force via the Administrator.

''(e) DUTIES.—

''(1) ADMINISTRATIVE DUTIES.—The Program shall—

''(A) prepare work and spending plans for implementing the activities of the Program and developing and implementing the Regional Research and Action Plans;

''(B) administer merit-based, competitive grant funding to support the projects maintained and established by the Program, and to address the research and management needs and priorities identified in the Regional Research and Action Plans;

''(C) coordinate NOAA programs that address harmful algal blooms and hypoxia and other ocean and Great Lakes science and management programs and centers that address the chemical, biological, and physical components of harmful algal blooms and hypoxia;

''(D) coordinate and work cooperatively with other Federal, State, and local government agencies and programs that address harmful algal blooms and hypoxia;

''(E) coordinate with the State Department to support international efforts on harmful algal bloom and hypoxia information sharing, research, mitigation, and control.''.

''(F) coordinate an outreach, education, and training program that integrates and augments existing programs to improve public education about and awareness of the causes, impacts, and mitigation efforts for harmful algal blooms and hypoxia;

''(G) facilitate and provide resources for training of State and local coastal and water resource managers in the methods and technologies for monitoring, controlling, and mitigating harmful algal blooms and hypoxia;

''(H) support regional efforts to control and mitigate outbreaks through—

''(i) communication of the contents of the Regional Research and Action Plans and maintenance of online data portals for other information about harmful algal blooms and hypoxia to State and local stakeholders within the region for which each plan is developed; and

''(ii) overseeing the development, review, and periodic updating of Regional Research and Action Plans established under section 602C(b);

''(I) convene an annual meeting of the Task Force; and

''(J) perform such other tasks as may be delegated by the Task Force.

''(2) NOAA DUTIES.—NOAA shall maintain and enhance—

''(A) the Ecology and Oceanography of Harmful Algal Blooms Program;

''(B) the Monitoring and Event Response for Harmful Algal Blooms Program;

''(C) the Northern Gulf of Mexico Ecosystems and Hypoxia Assessment Program; and

''(D) the Coastal Hypoxia Research Program.

''(3) PROGRAM DUTIES.—The Program shall—

''(A) establish—

''(i) a Mitigation and Control of Harmful Algal Blooms Program—

''(I) to develop and promote strategies for the prevention, mitigation, and control of harmful algal blooms; and

''(II) to fund research that may facilitate the prevention, mitigation, and control of harmful algal blooms; and

''(III) to develop and demonstrate technology that may mitigate and control harmful algal blooms; and

''(ii) other programs as necessary; and

''(B) work cooperatively with other offices, centers, and programs within NOAA and other agencies represented on the Task Force, States, and nongovernmental organizations concerned with marine and aquatic issues to manage data, products, and infrastructure, including—

''(i) compiling, managing, and archiving data from relevant programs in Task Force member agencies;

''(ii) creating data portals for general education and data dissemination on centralized, publicly available databases; and

''(iii) establishing communication routes for data, predictions, and management tools both to and from the regions, states, and local communities.''.

SEC. 7. REGIONAL RESEARCH AND ACTION PLANS.

The Act, as amended by section 6, is amended by inserting after section 602A the following:

''SEC. 602B. REGIONAL RESEARCH AND ACTION PLANS.

''(a) IN GENERAL.—The Program shall—

''(1) oversee the development and implementation of Regional Research and Action Plans; and

''(2) identify appropriate regions and subregions to be addressed by each Regional Research and Action Plan.

''(b) REGIONAL PANELS OF EXPERTS.—

''(1) IN GENERAL.—In accordance with the schedule set forth in paragraph (2), the Program shall convene a panel of experts for each region identified under subsection (a)(2) from among—

''(A) State coastal management and planning officials;

''(B) water management and watershed officials from both coastal states and noncoastal states with water sources that drain into water bodies affected by harmful algal blooms and hypoxia;

''(C) public health officials;

''(D) emergency management officials;

''(E) nongovernmental organizations concerned with marine and aquatic issues;

''(F) science and technology development institutions;

''(G) economists;

''(H) industries and businesses affected by coastal and freshwater harmful algal blooms and hypoxia;

''(I) scientists, with expertise concerning harmful algal blooms or hypoxia, from academic or research institutions; and

''(J) other stakeholders as appropriate.

''(2) SCHEDULE.—The Program shall—

''(A) convene panels in at least ⅓ of the regions within 9 months after the date of enactment of the Harmful Algal Blooms and Hypoxia Research and Control Amendments Act of 2009;

''(B) convene panels in at least ⅔ of the regions within 21 months after such date; and

''(C) convene panels in the remaining regions within 33 months after such date; and

''(D) reconvene each panel at least every 5 years after the date on which it was initially convened.

''(c) PLAN DEVELOPMENT.—Each regional panel of experts shall develop a Regional Research and Action Plan for its respective region and submit it to the Program for approval and to the Task Force. The Plan shall identify appropriate elements for the region, including—

''(1) baseline ecological, social, and economic research needed to understand the biological, physical, and chemical conditions that cause, exacerbate, and result from harmful algal blooms and hypoxia;

''(2) regional priorities for ecological and socio-economic research on issues related to, and impacts of, harmful algal blooms and hypoxia;

''(3) research needed to develop and advance technologies for improving capabilities to predict, monitor, prevent, control, and mitigate harmful algal blooms and hypoxia;

''(4) State and local government actions that may be implemented—

''(A) to support long-term monitoring efforts and emergency monitoring as needed;

''(B) to minimize the occurrence of harmful algal blooms and hypoxia;

''(C) to reduce the duration and intensity of harmful algal blooms and hypoxia in times of emergency;

''(D) to address human health dimensions of harmful algal blooms and hypoxia; and

''(E) to identify and protect vulnerable ecosystems that could be, or have been, affected by harmful algal blooms and hypoxia;

''(5) mechanisms by which data and products are transferred between the Program and State and local governments and research entities;

''(6) communication, outreach and information dissemination efforts that State and local governments and nongovernmental organizations can undertake to educate and inform the public concerning harmful algal blooms and hypoxia and alternative coastal resource-utilization opportunities that are available; and

''(7) pilot projects, if appropriate, that may be implemented on local, State, and regional scales to address the research priorities and response actions identified in the Plan.

''(d) PLAN TIMELINES; UPDATES.—The Program shall ensure that Regional Research and Action Plans developed under this section are—

''(1) completed and approved by the Program within 12 months after the date on which a regional panel is convened or reconvened under subsection (b)(2); and

''(2) updated no less frequently than once every 5 years.

''(e) FUNDING.—

''(1) IN GENERAL.—Subject to available appropriations, the Program shall make funding available to eligible organizations to implement the research, monitoring, forecasting, modeling, and response actions included under each approved Regional Research and Action Plan. The Program shall select recipients through a merit-based, competitive process and seek to fund research proposals that most effectively align with the research priorities identified in the relevant Regional Research and Action Plan.

''(2) APPLICATION; ASSURANCES.—Any organization seeking funding under this subsection shall submit an application to the Program at such time, in such form and manner, and containing such information and assurances as the Program may require. The Program shall require any organization receiving funds under this subsection to utilize the mechanisms described in subsection (c)(5) to ensure the transfer of data and products developed under the Plan.

''(3) ELIGIBLE ORGANIZATION.—In this subsection, the term 'eligible organization' means—

''(A) a nongovernmental researcher or organization; or

''(B) any other entity that applies for funding to implement the State, local, and nongovernmental control, mitigation, and prevention strategies identified in the relevant Regional Research and Action Plan.

''(f) INTERMEDIATE REVIEWS.—If the Program determines that an intermediate review is necessary to address emergent needs in harmful algal blooms and hypoxia under a Regional Research and Action Plan, it shall notify the Task Force and reconvene the relevant regional panel of experts for the purpose of revising the Regional Research and Action Plan so as to address the emergent threat or need.''.

SEC. 8. REPORTING.

Section 603, as amended by section 5, is amended by adding at the end thereof the following:

''(c) BIENNIAL REPORTS.—Every 2 years the Program shall prepare a report for the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committees on Science and Technology and on Natural Resources that describe—

''(1) activities, budgets, and progress on implementing the national harmful algal bloom and hypoxia program;

''(2) the proceedings of the annual Task Force meetings; and

''(3) the status, activities, and funding for implementation of the Regional Research and Action Plans, including a description of research funded under the program and actions and outcomes of Plan response strategies carried out by States.

''(d) QUINQUENNIAL REPORTS.—Not less than once every 5 years after the date of enactment of the Harmful Algal Blooms and Hypoxia Research and Control Amendments Act of 2009, the Task Force shall complete and submit a report on harmful algal blooms and hypoxia in marine and freshwater systems to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committees on Science and Technology and on Natural Resources. The report shall—

''(1) evaluate the state of scientific knowledge of harmful algal blooms and hypoxia in marine and freshwater systems, including their causes and ecological consequences;

''(2) evaluate the social and economic impacts of harmful algal blooms and hypoxia, including their impacts on coastal communities, and review those communities' efforts and associated economic costs related to event forecasting, planning, mitigation, response, and public outreach and education;

''(3) examine and evaluate the human health impacts of harmful algal blooms and hypoxia, including any gaps in existing research;

''(4) describe advances in capabilities for monitoring, forecasting, modeling, control, mitigation, and prevention of harmful algal blooms and hypoxia, including techniques for, integrating landscape- and watershed-level water quality information into marine and freshwater harmful algal bloom and hypoxia prevention and mitigation strategies at Federal and regional levels;

''(5) evaluate progress made by, and the needs of, Federal, regional, State, and local policies and strategies for forecasting, planning, mitigating, preventing, and responding to harmful algal blooms and hypoxia, including the economic costs and benefits of such policies and strategies;

''(6) make recommendations for integrating, improving, and funding future Federal, regional, State, and local policies and strategies for preventing and mitigating the occurrence and impacts of harmful algal blooms and hypoxia; and

''(7) describe communication, outreach, and education efforts to raise public awareness of harmful algal blooms and hypoxia, their impacts, and the methods for mitigation and prevention.''.

SEC. 9. NORTHERN GULF OF MEXICO HYPOXIA.

Section 604 is amended to read as follows:

''SEC. 604. NORTHERN GULF OF MEXICO HYPOXIA.

(a) TASK FORCE ANNUAL PROGRESS REPORTS.—For each of the years from 2009 through 2013, the Mississippi River/Gulf of Mexico Watershed Nutrient Task Force shall complete and submit to the Congress and the President an annual report on the progress made by Task Force-directed activities toward attainment of the Coastal Goal of the Gulf Hypoxia Action Plan 2008.

(b) TASK FORCE 5-YEAR PROGRESS REPORT.—In 2013, that Task Force shall complete and submit to Congress and the President a 5-Year report on the progress made by Task Force-directed activities toward attainment of the Coastal Goal of the Gulf Hypoxia Action Plan 2008. The report shall assess progress made toward nutrient load reductions, the response of the hypoxic zone and water quality throughout the Mississippi/Atchafalaya River Basin, and the economic and social effects. The report shall include an evaluation of how current policies and programs affect management decisions, including those made by municipalities and industrial and agricultural producers, evaluate lessons learned, and recommend appropriate actions to continue to implement or, if necessary, revise this strategy.

SEC. 10. PILOT PROGRAM FOR FRESHWATER HARMFUL ALGAL BLOOMS AND HYPOXIA.

The Act, as amended by section 7, is amended by inserting after section 603B the following:

''SEC. 603C. PILOT PROGRAM FOR FRESHWATER HARMFUL ALGAL BLOOMS AND HYPOXIA.

''(a) PILOT PROGRAM.—The Secretary shall establish a collaborative pilot program with the Environmental Protection Agency and other appropriate Federal agencies to examine harmful algal blooms and hypoxia occurring in freshwater systems, including the Great Lakes. The pilot program shall—

''(1) assess the issues associated with, and impacts of, harmful algal blooms and hypoxia in freshwater ecosystems;

''(2) research the efficacy of mitigation measures, including measures to reduce nutrient loading; and

''(3) recommend potential management solutions.

''(b) REPORT.—The Secretary of Commerce, in consultation with other participating Federal agencies, shall conduct an assessment of the effectiveness of the pilot program in improving freshwater habitat quality and publish a report, available to the public, of the results of the assessment.''.

SEC. 11. INTERAGENCY FINANCING.

The Act is amended by inserting after section 604 the following:

''SEC. 604A. INTERAGENCY FINANCING.

''The departments and agencies represented on the Task Force are authorized to participate in interagency financing and share, transfer, receive, obligate, and expend funds appropriated to any member of the Task Force for the purposes of carrying out any administrative or programmatic project or activity under this Act, including support for the Program, a common infrastructure, information sharing, and system integration for harmful algal bloom and hypoxia research, monitoring, forecasting, prevention, and control. Funds may be transferred among such departments and agencies through an appropriate instrument that specifies the goods, services, or space being acquired from another Task Force member and the costs of the same.''.

SEC. 12. APPLICATION WITH OTHER LAWS.

The Act is amended by inserting after section 606 the following:

''SEC. 607. EFFECT ON OTHER FEDERAL AUTHORITY.

''Nothing in this title supersedes or limits the authority of any agency to carry out its responsibilities and missions under other laws.''.

SEC. 13. DEFINITIONS.

(a) IN GENERAL.—The Act is amended by inserting after section 605 the following:

''SEC. 605A. DEFINITIONS.

''In this Act:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the NOAA.

''(2) HARMFUL ALGAL BLOOM.—The term 'harmful algal bloom' means marine and freshwater phytoplankton that proliferate to high concentrations, resulting in nuisance conditions or harmful impacts on marine and aquatic ecosystems, coastal communities, and human health through the production of toxic compounds or other biological, chemical, and physical impacts of the algae outbreak.

''(3) HYPOXIA.—The term 'hypoxia' means a condition where low dissolved oxygen in aquatic systems causes stress or death to resident organisms.

''(4) NOAA.—The term 'NOAA' means the National Oceanic and Atmospheric Administration.

''(5) PROGRAM.—The term 'Program' means the Integrated Harmful Algal Bloom and Hypoxia Program established under section 603A.

''(6) REGIONAL RESEARCH AND ACTION PLAN.—The term 'Regional Research and Action Plan' means a plan established under section 602B.

''(7) SECRETARY.—The term 'Secretary' means the Secretary of Commerce, acting through NOAA.''.

''(8) TASK FORCE.—The term 'Task Force' means the Interagency Task Force established by section 603(a).

''(9) UNITED STATES COASTAL WATERS.—The term 'United States coastal waters' includes the Great Lakes.''.

(b) CONFORMING AMENDMENT.—Section 603(a) is amended by striking ''Hypoxia (hereinafter referred to as the 'Task force').'' and inserting ''Hypoxia.''.

SEC. 14. AUTHORIZATION OF APPROPRIATIONS.

Section 605 is amended to read as follows:—

''SEC. 605. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—There are authorized to be appropriated to NOAA to implement the Program under this title $40,000,000 for each of fiscal years 2010 through 2014, of which up to $10,000,000 shall be allocated each fiscal year to the creation of Regional Research and Action Plans required by section 602B.

''(b) EXTRAMURAL RESEARCH ACTIVITIES.—The Secretary shall ensure that a substantial portion of funds appropriated pursuant to subsection (a) that are used for research purposes are allocated to extramural research activities.

''(c) PILOT PROGRAM.—In addition to any amounts appropriated pursuant to subsection (a), there are authorized to be appropriated to NOAA such sums as may be necessary to carry out the pilot program established under section 603C.''.

Mr. NELSON of Florida. Mr. President, I rise today to introduce legislation that will address an ongoing problem that adversely affects local communities and coastal areas around my home State of Florida and across coastal and Great Lakes States.

Today, Senator SNOWE and I, along with Senators BOXER, CANTWELL, CARDIN, LANDRIEU, LEVIN and VITTER. introduced a bill that would reauthorize and enhance the Harmful Algal Bloom and Hypoxia Research and Control Act, HABHRCA, which was enacted in 1998 and reauthorized 5 years ago. This act enabled critical monitoring, forecasting, and research activities that have greatly improved our understanding and prediction of harmful algal blooms, nuisance blooms like red drift, and low-oxygen or hypoxia events that plague our estuaries and coastal waters.

We have made great strides through HABHRCA to address this problem, but there is more yet to do. Reports of harmful algal blooms in U.S. waters and around the world have drastically increased over the past 3 decades.

Harmful algae can produce potent toxins causing illness and death in humans, fish, seabirds, marine mammals like manatees and dolphins, and other oceanic life. Other harmful algae are non-toxic to humans, but can still cause damage to ecosystems, corals, fisheries resources, and recreational facilities. Harmful algae also have a significant economic impact. A 2006 study conservatively estimated that coastal harmful algal blooms cost more than $82 million per year on average in the U.S., with the majority of impacts in the public health and commercial fisheries sectors.

Virtually every coastal state in the country is affected by harmful algal blooms. For instance, toxins from harmful algae found in razor clams along the Pacific Coast eventually shut down Washington's clam fishery in 2002. This event resulted in $10–12 million in lost revenue. In 2005, a red tide event in New England caused closures of shellfish harvesting to prevent paralytic shellfish poisoning in humans. These closures resulted in approximately $18 million in lost shellfish sales in Massachusetts and $4.9 million in Maine. In Hawaii, macroalgal blooms, which impact coral reefs and local aesthetics, result in more than $20 million in lost revenue every year due to reductions in real estate value, lost hotel business, and increased clean-up costs.

A particularly devastating and intense red tide struck the Gulf Coast of my home State of Florida in the summer of 2005, causing widespread animal deaths as well as public health and economic problems. The St. Petersburg/Clearwater Area Convention and Visitors Bureau estimated upwards of $240 million in losses for the Tampa region as a result of this bloom.

Scientists have told us that red tides are a lot like hurricanes—complex but natural phenomena that can have profound impacts on our environment and society. Although we may not be able to stop this natural process, we can do more to predict it and take actions to minimize its impacts on our citizens and natural resources.

In April 2008, researchers predicted a severe outbreak of New England Red Tide, Alexandrium fundyense, which produces potent neurotoxins that are filtered by shellfish. When humans consume contaminated shellfish they become extremely ill and can die without immediate medical treatment. This was the first time that researchers could issue a prediction of this kind several weeks in advance. The 2008 prediction was derived from a model based on 10 years of ecosystem research in the Gulf of Maine. The prediction was remarkably accurate, and it allowed State managers and the shellfish aquaculture industry to plan for a difficult season. By showing the news media and the public that the event was expected and that state managers were prepared, the prediction may have also reduced the ''halo'' effect in which shellfish harvesting closures in one area reduce shellfish and fish sales from areas unaffected by toxicity. This prediction was made possible from research funded under programs authorized by HABARCA.

It is clear that harmful algal blooms and hypoxia events can have devastating impacts on water and air quality, aquatic species, wildlife, and beach conditions, which in turn affect public health, commercial and recreational fishing, tourism, and related businesses in our coastal communities. The question becomes, what can we do to stop this? If we can't stop these events, how can we better plan for them and take steps to minimize the impacts?

We have learned from scientists and researchers that some harmful algal blooms and red drift events can be triggered by excess nutrients from upland areas that wash into rivers and are delivered to the coast. Because this problem often crosses political and geographic boundaries, we must pursue solutions that are regional in nature and bring together expertise from all levels of government, from academia, and from other outside groups who have a stake in keeping our coastal waters healthy, clean, and productive.

Senator SNOWE and I have worked together to craft a bill that will not only continue critical research on harmful algal blooms and hypoxia, but will help address some of these pressing needs that exist on every coast—from the Atlantic and Gulf of Mexico, to the Pacific and the Great Lakes. Our bill will

help to integrate and improve coordination among the government's programs that study and monitor these events. The bill also would improve how regional, state, and local needs are considered when prioritizing research grants and developing related products. Most importantly, this bill would focus new resources on translating research results into tools and products that state and local governments can use to help prevent, respond to, and mitigate the impacts of these events.

Although we have made significant progress in identifying some of the causes and consequences of harmful algal blooms and hypoxia since 1998, much work remains to find solutions that minimize the occurrence of these events and enable our coastal communities to become resilient to the impacts. This legislation to amend and reauthorize the Harmful Algal Blooms and Hypoxia Act represents an important step toward realizing those goals.

In closing, I would like to recognize Senator SNOWE for her leadership on this issue. As the sponsor of both the original legislation in 1998 and the 2004 amendments, her expertise on harmful algal blooms and the impacts of these events on her constituents has proved invaluable as we developed the measure before us today. I look forward to working with Senator SNOWE, in her role as ranking member of the Oceans, Atmosphere, Fisheries, and Coast Guard Subcommittee of the Commerce, Science, and Transportation Committee, as well as with Chairman CANTWELL and the other members of the subcommittee, to debate this important legislation.

By Mr. HARKIN:

S. 953. A bill to provide for the establishment of programs and activities to increase influenza vaccination rates through the provision of free vaccines; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I am introducing the Seasonal Influenza and Pandemic Preparation Act of 2009. The bill was given the number S. 953. This bill would establish a nationwide free, voluntary influenza vaccination program, under which any individual in this country may receive an annual influenza vaccine shot free of charge.

I offered this bill 3 years ago because at that time we started the process of building up our vaccine capacity. I will have more to say about that. What is happening currently with H1N1 being almost at a pandemic stage now, it brings home again what we need to do in this country to be prepared, and that is what this bill is about. Offering free flu shots to everyone in the United States is a good idea in and of itself.

The Centers for Disease Control and Prevention says an average of more than 40,000 Americans die each year from flu-related diseases and causes. Think about that: 40,000 Americans die every year due to flu-related causes. Seasonal flu is responsible for more than 31 million outpatient visits and more than 3 million days annually in the hospital. Seasonal flu costs the U.S. economy nearly $90 billion annually, including $10 billion in direct medical costs—$10 billion a year just in direct medical costs. Think about that: 40,000 people dying every year, $10 billion in direct medical costs, $90 billion annually in lost productivity to our economy, over 3 million days in the hospital every year, and this is seasonal flu.

We can significantly reduce all those numbers. In addition, there is some evidence that people who are vaccinated each year against seasonal flu viruses actually build up a limited degree of resistance to pandemic viruses. So strictly as a matter of prudent prevention, it is desirable to maximize the number of Americans who are vaccinated against flu each year. By offering the vaccinations for free and making them conveniently available, we would remove major barriers to more widespread participation.

There is precedence for this. Medicare, right now, will pay for one seasonal flu shot for everybody on Medicare every year. So we already have that out there. We just need to get it to the rest of the population.

There are other compelling reasons for establishing a nationwide voluntary free flu vaccination program. Let me explain.

As chairman of the appropriations subcommittee that funds health programs, I have taken the lead in the past in providing funding to prepare for a future flu pandemic. Since 2006, my subcommittee has provided more than $6 billion to these activities.

As a consequence, while public health authorities in the United States may have been surprised by the H1N1 virus outbreak, they have not been caught unprepared. To the contrary, since 2006 we have undertaken very robust measures to prepare for exactly this kind of outbreak and potential pandemic.

First, we have made major investments in antivirals that can be given to a person once exposed and shows signs of the illness. We have made major investments in medical equipment, which are right now, as we speak, being distributed nationally to our local public health authorities across the country. Many of them are now in place. Many started going out earlier this week. I daresay that probably most, if not all, of them are probably out there right now—from the stockpiles that we built up. There are over 50 million doses of Tamiflu and Relenza that we built up in our stockpile. Well, not all of that, but most of it, has gone out around the country to be prepared.

Second, we have stepped up our public health and surveillance activities, which helped us to detect the H1N1 virus earlier than we otherwise might have.

Third, we have increased the capacity of the Centers for Disease Control and Prevention to identify viruses and respond aggressively and very immediately, including producing what is called a ''seed'' virus, necessary for the development of a vaccine. That is being done right now.

Fourth, we have also made major investments in building up our vaccine production capacity in the United States. Mr. President, when we started on this in 2005, there was at that time only one plant in the entire United States of America that could produce flu vaccines—one. I believe it is located in Pennsylvania, and that was making vaccines based upon an old methodology of using eggs. We had to use millions of eggs every year to produce that vaccine, and that takes a long time.

There have been, in the research and development, processes by which we can make cell-based vaccines. We can shorten the timeframe. That is nice, but we don't have any cell-based plants in the United States. In the fiscal 2006 bill, we put over $3 billion out there to build these plants. They are being built now. So we are building up our vaccine production capacity and doing it in a way in which we can get the vaccines produced more rapidly.

Fifth, we have funded research into adjuvants. These are agents that increase the vaccine's effectiveness. Let me put it this way. If we have one dose of a vaccine, we might actually be able to cut that dose down and give that one dose to four or five people by adding the adjuvant to it.

Lastly, we have worked with State and local public health agencies to boost their capacity to respond to a flu pandemic. We have done that, but because of the economic downturn many of our State budgets have been slashed. In our States around the country, we were told at our hearing the other day, over 60,000 people have been laid off from our public health agencies. That makes it more difficult to get the antivirals out to people who may come down with H1N1 or any other kind of flu virus.

Because of all these things we did, I think I can safely say there is no reason for anyone anywhere in the United States to panic because of the H1N1 flu virus. As I said, one of the most important things we have done is to build up our vaccine manufacturing capacity.

Here is the problem. This really is the crux of this bill I have introduced today. Say we build up the vaccine manufacturing capacity and we build these plants that can respond aggressively and immediately to a pandemic outbreak. What happens the rest of the time? What happens? Do they sit there idle, not being utilized? We cannot have that.

What we need to do is to use these plants, then, to make more of the seasonal flu vaccines every year. Well, if we have the plants out there, and they make more of the seasonal flu viruses but not everybody is using them, what do we do, just throw it away? We want the plant capacity to prepare for any

pandemic in the future, but they need to be active and they need to produce annually. If they are going to produce annually, then we have to find something to do with these vaccines.

By offering annual free vaccines to every single person in America, we will keep our vaccine production capacity up and running. It will be ready to shift at a moment's notice, when necessary, from producing seasonal flu vaccines to a mass production of vaccines to fight any future outbreak or pandemic.

There is another reason for this bill. If we are faced with a flu virus pandemic, we are going to have to mobilize people. We are going to have to get the vaccines out in a hurry and get the vaccines right down to the individual people all over this country—people in small towns and communities, in rural areas, and in cities. Well, by having an annual free flu vaccination, we will give public health agencies across America valuable experience in administering vaccines to masses of people, local agencies that will have a reason to develop trained cadres of people who are capable of administering vaccines.

We will also develop an established network of sites that might include grocery stores, shopping malls, schools, places of worship, and senior centers where people can conveniently go to get vaccinated in case of an outbreak. These annual activities will significantly increase State and local public health readiness to fight a pandemic. Not all these people are going to be employed by the Government. These will be volunteers, but they will be trained. They will know where to go and how to administer a vaccine because they will be doing it on an annual basis, free of charge, to people. We will build up a network of sites and a cadre of people who can be relied upon in case we face a pandemic.

On Tuesday, in response to the H1N1 outbreak, I chaired an emergency hearing on the Health Appropriations Subcommittee. We heard assessments of the outbreak from top medical experts, including Dr. Anthony Fauci, the renowned and remarkable Director of the National Institute of Allergy and Infectious Diseases at NIH.

Years ago, when we first started this, back in 2005, Dr. Fauci warned us that it is not a matter of ''whether'' there will be a flu pandemic but rather ''when'' it will happen. It is not a matter of whether but when.

When the Senate drafted its version of the American Recovery and Reinvestment Act this year—the stimulus bill—I included an additional $870 million for pandemic preparedness. Most of that funding was to be used to complete the work of building up our vaccine production capacity; in other words, to get these plants built more rapidly. Unfortunately, it was taken out in the final bill. Again, what we are trying to do is shift from egg-based production to cell-based production, so we can get these vaccines developed more rapidly. Taking it out of the stimulus bill was the typical shortsighted resistance that I have often encountered when I talk about this.

Some accused me a couple years ago of crying wolf. The wolf is here. One day in the future we can encounter an even worse wolf, such as the flu pandemic of 1918, which was the Spanish flu. It infected one out of three people worldwide and killed more than 50 million people. It would be the height of folly not to do what we can to prepare for such a possibility. The harsh reality is that we have repeatedly experienced flu pandemics. I mentioned the one of 1918 and 1919.

There was the Asian flu pandemic of 1957 and 1958 that killed over 1.5 million people.

The Hong Kong flu pandemic of 1968 and 1969 killed over 1 million people. Not only did it kill over 1 million people, it caused hundreds of millions of illnesses and hospital stays all across the globe.

We cannot predict the future course or severity of the current H1N1 outbreak, but clearly it is one more wake-up call.

Again, I am reintroducing the Seasonal Influenza and Pandemic Preparation Act today as a stand-alone bill. I first introduced it in 2005, as I said. It is now a stand-alone bill. We either pass it that way or, if not, I plan to incorporate it into the prevention and public health title of comprehensive health reform legislation that we will hopefully pass this year. A program offering annual free flu shots to every American is exactly the kind of smart, cost-effective, prevention-focused public health that must be at the center of our reformed health care system in America. It will save lives and money. When—when not whether—a pandemic flu strikes the U.S. in the future, we will be ready.

I encourage Senators to cosponsor the legislation. I think this is one more wake-up call and we have to move ahead aggressively in preparing for these pandemics. As Dr. Fauci said, it is not a question of whether, it is only a question of when and how severe it will be. We don't know.

I remind people that a few years ago when we started this, back in 2005, we were confronting the possible pandemic of an avian flu or H5N1 flu, which started in Southeast Asia. Thanks to surveillance, to the CDC, and to a lot of people working on it, we were able to contain it. That H5N1 avian flu is one of the most deadly we have confronted, with over a 50-percent mortality. One out of every two persons who contracted it died. Now we have contained it and tamped it down. That H5N1 virus is still out there and, periodically, we pick it up in places such as Southeast Asia.

There was a thought that because of migratory birds, it may be spread to other places, but we don't know that.

But because it has reared its ugly head, because we know that virus is out here someplace, it behooves us to do everything we can to protect the people of this country and in doing so to prepare. I hope it doesn't happen. I hope when there is a pandemic flu, it will be just a mild one and will not kill people. But we don't know. The best way to prepare for it is to build up our vaccine-manufacturing capacity as rapidly as possible; secondly, make sure our public health agencies on the State and local levels are ready to go, that they are trained, that they are equipped; and thirdly, that we have some experience, that we know how to do this.

One of the best ways is to give everyone a free flu shot every year—everyone, a voluntary free flu shot every year. To me, that will set us up well to prepare for and to protect the American people against any flu pandemic that may come our way in the future.

By Mr. DURBIN (for himself, Mr. BINGAMAN, Mr. CASEY, and Mr. FEINGOLD):

S. 957. A bill to amend the Public Health Service Act to ensure that victims of public health emergencies have meaningful and immediate access to medically necessary health care services; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN: Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 957

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Public Health Emergency Response Act of 2009''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds the following:

(1) Since 2000, the Secretary of Health and Human Services has declared that a public health emergency existed nationwide in response to the attacks of September 11th and in response to Hurricanes Katrina and Rita.

(2) In the event of a public health emergency, compliance with recommendations to seek immediate care may be critical to containing the spread of an infectious disease outbreak or responding to a bioterror attack.

(3) Nearly 16 percent of Americans lack health insurance coverage.

(4) Fears of out-of-pocket expenses may cause individuals to delay seeking medical attention during a public health emergency.

(5) A public health emergency may disrupt health care assistance programs for individuals with chronic conditions, exacerbating the costs and risks to their health.

(6) The uninsured could place great financial strain on health care providers during a public health emergency.

(7) The Department of Health and Human Services Pandemic Influenza Plan projects that a pandemic influenza outbreak could result in 45,000,000 additional outpatient visits, with 865,000 to 9,900,000 individuals requiring hospitalization, depending upon the severity of the pandemic.

(8) Hospitals in the United States could lose as much as $3,900,000,000 in uncompensated care and cash flow losses in the event of a severe pandemic.

(9) Under current statute, no dedicated mechanism exists to reimburse providers for uncompensated care during a public health emergency.

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

(1) to provide temporary emergency health care coverage for uninsured and certain otherwise qualified individuals in the event of a public health emergency declared by the Secretary of Health and Human Services;

(2) to ensure that health care providers remain fiscally solvent and are not overburdened by the cost of uncompensated care during a public health emergency;

(3) to eliminate a primary disincentive for uninsured and certain otherwise qualified individuals to promptly seek medical care during a public health emergency; and

(4) to minimize delays in the provision of emergency health care coverage by clarifying eligibility requirements and the scope of such coverage and identifying the funding mechanisms for emergency health care services.

SEC. 3. EMERGENCY HEALTH CARE COVERAGE.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 319K the following new section:

"SEC. 319K–1. EMERGENCY HEALTH CARE COVERAGE.

''(a) ACTIVATION AND TERMINATION OF EMERGENCY HEALTH CARE COVERAGE.—

''(1) BASED ON PUBLIC HEALTH EMERGENCY.—

''(A) IN GENERAL.—The Secretary may activate the coverage of emergency health care services under this section only if the Secretary determines that there is a public health emergency.

''(B) DETERMINATION OF PUBLIC HEALTH EMERGENCY.—For purposes of this section, there is a 'public health emergency' only if a public health emergency exists under section 319.

''(2) CONSIDERATIONS.—In making a determination under paragraph (1), the Secretary shall consider a range of factors including the following:

''(A) The degree to which the emergency is likely to overwhelm health care providers in the region.

''(B) The opportunity to minimize morbidity and mortality through intervention under this section.

''(C) The estimated number of direct casualties of the emergency.

''(D) The potential number of casualties in the absence of intervention under this section (such as in the case of infectious disease).

''(E) The potential adverse financial impacts on local health care providers in the absence of activation of this section.

''(F) Whether the need for health care services is of sufficient severity and magnitude to warrant major assistance under this section above and beyond the emergency services otherwise available from the Federal Government.

''(G) Such other factors as the Secretary may deem appropriate.

''(3) TERMINATION AND EXTENSION.—

''(A) IN GENERAL.—Coverage of emergency health care services under this section shall terminate, subject to subsection (c)(2), upon the earlier of the following:

''(i) The Secretary's determination that a public health emergency no longer exists.

''(ii) Subject to subparagraph (B), 90 days after the initiation of coverage of emergency health care services.

''(B) EXTENSION AUTHORITY.—The Secretary may extend a public health emergency for a second 90-day period, but only if a report to Congress is made under paragraph (4) in conjunction with making such extension.

''(4) REPORT.—

''(A) IN GENERAL.—Prior to making an extension under paragraph (3)(B), the Secretary shall transmit a report to Congress that includes information on the nature of the public health emergency and the expected duration of the emergency. The Secretary shall include in such report recommendations, if deemed appropriate, that Congress provide a further extension of the public health emergency period beyond the second 90-day period.

''(B) REPORT CONTENTS.—A report under subparagraph (A) shall include a discussion of the health care needs of emergency victims and affected individuals including the likely need for follow-up care over a 2-year period.

''(5) COORDINATION.—The Secretary shall ensure that the activation, implementation, and termination of emergency health care services under this section in response to a public health emergency is coordinated with all functions, personnel, and assets of the Federal, State, local, and tribal responses to the emergency.

''(6) MEDICAL MONITORING PROGRAM.—The Secretary shall establish a medical monitoring program for monitoring and reporting on health care needs of the affected population over time. At least annually during the 5-year period following the date of a public health emergency, the Secretary shall report to Congress on any continuing health care needs of the affected population related to the public health emergency. Such reports shall include recommendations on how to ensure that emergency victims and affected individuals have access to needed health care services.

''(b) ELIGIBILITY FOR COVERAGE OF EMERGENCY HEALTH CARE SERVICES.—

''(1) LIMITED ELIGIBILITY.—

''(A) IN GENERAL.—Eligibility for coverage of emergency health care services under this section for a public health emergency is limited to individuals who—

''(i) are emergency victims who are uninsured or otherwise qualified; or

''(ii) are affected individuals who are uninsured.

''(B) DEFINITIONS.—For purposes of this section with respect to a public health emergency:

''(i) INSURED.—An individual is 'insured' if the individual has group or individual health insurance coverage or publicly financed health insurance (as defined by the Secretary).

''(ii) OTHERWISE QUALIFIED.—An individual is ''otherwise qualified'' if the individual is insured but the Secretary determines that the individual's health care insurance coverage is not at least actuarially-equivalent to benchmark coverage. In establishing such benchmark coverage, the Secretary shall consider the standard Blue Cross/Blue Shield preferred provider option service benefit plan described in and offered under section 8903(1) of title 5, United States Code.

''(iii) UNINSURED.—An individual is 'uninsured' if the individual is not insured.

''(iv) EMERGENCY VICTIM.—An individual is an 'emergency victim' with respect to a public health emergency if the individual needs health care services due to injuries or disease resulting from the public health emergency.

''(v) AFFECTED INDIVIDUAL.—An individual is an 'affected individual' with respect to a public health emergency if—

''(I) the individual—

''(aa) resides in an assistance area designated for the emergency (or whose residence was displaced by the emergency); or

''(bb) in the case of such an emergency constituting a pandemic flu or other infectious disease outbreak, resides in the area affected by the outbreak (or whose residence was displaced by the emergency); and

''(II) the individual's ability to access care or medicine is disrupted as a result of the emergency.

''(2) PROCESS.—The Secretary shall establish a streamlined process for determining eligibility for emergency health care services under this section. In establishing such process—

''(A) the Secretary shall recognize that in the context of a public health emergency, individuals may be unable to provide identification cards, health care insurance information, or other documentation; and

''(B) the primary method for determining eligibility for such services shall be an attestation provided to the health care provider by the recipient of the services that the recipient meets the eligibility criteria established under paragraph (1)(A), with a standard alternative for unattended minors and adults without the capacity to sign such an attestation form.

''(3) SERVICE DELIVERY.—Providers may commence provision of emergency health care services for an individual in the absence of any centralized enrollment process, if the provider has collected basic information, specified by the Secretary, including the individual's name, address, social security number, and existing health insurance coverage (if any), that establishes a prima facie basis for eligibility, except that such information shall not be required in cases where the individual is unable to provide the information due to disability or incapacitation.

''(c) EMERGENCY HEALTH CARE SERVICES.—

''(1) IN GENERAL.—For purposes of this section, the term 'emergency health care services'—

''(A) means items and services for which payment may be made under parts A and B of the Medicare program;

''(B) includes prescription drugs (not covered under such part B) specified by the Secretary under subsection (g), based on the formularies of the two or more prescription drug plans under part D of the Medicare program with the largest enrollment;

''(C) may include drugs, devices, biological products, and other health care products, if such products are authorized for use by the Food and Drug Administration pursuant to an alternate authority, including the emergency use authority under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3); and

''(D) for an affected individual, is limited to those items and services described under subparagraphs (A), (B) or (C) that a third-party payor, such as a government program or charitable organization, reimbursed or otherwise provided to an affected individual during the 90 days prior to the declaration of the public health emergency.

''(2) NOT MEDICARE, MEDICAID, OR SCHIP BENEFITS.—The emergency health care services provided under this section are not benefits under Medicare, Medicaid or SCHIP. Nothing in this section shall be interpreted as altering or otherwise conflicting with titles XVIII, XIX, or XXI of the Social Security Act.

''(3) COMPLETION OF TREATMENT FOR EMERGENCY VICTIMS.—Notwithstanding termination of the coverage of emergency health care services pursuant to subsection (a)(3), the Secretary may identify a subgroup of emergency victims on a case-by-case basis or otherwise to continue receiving coverage of emergency health care services for up to an additional 60 days. Such emergency health care services provided after the termination date shall be limited to services and items

that are medically necessary to treat an injury or disease resulting directly from the public health emergency involved.

''(d) COVERED PROVIDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), health care services are not covered under this section unless they are furnished by a health care provider that—

''(A) has a valid provider number under the Medicare program, the Medicaid program, or SCHIP;

''(B) is in good standing with such program; and

''(C) is not excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))).

''(2) WAIVER AUTHORITY.—

''(A) IN GENERAL.—The Secretary may by regulation waive certain requirements for provider enrollment that otherwise apply under the Medicare or Medicaid program or under SCHIP to ensure an adequate supply of health care providers (such as nurses and other health care providers who do not typically participate in the Medicare or Medicaid program or SCHIP) and services in the case of a public health emergency. Such requirements may include the requirement that a licensed physician or other health care professional holds a license in the State in which the professional provides services or is otherwise authorized under State law to provide the services involved.

''(B) REPORT ON EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR–VHP).—Not later than 180 days after the date of the enactment of this section, the Secretary shall submit to Congress a report on the number of volunteers, by profession and credential level, enrolled in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR–VHP) that will be available to each State in the event of a public health emergency. The Secretary shall determine if the number of such volunteers is adequate for interstate deployment in response to regional requests for volunteers and, if not, shall include in the report recommendations for actions to ensure an adequate surge capacity for public health emergencies in defined geographic areas.

''(3) MEDICARE AND MEDICAID PROGRAMS AND SCHIP DEFINED.—For purposes of this section:

''(A) The term 'Medicare program' means the program under parts A, B, and D of title XVIII of the Social Security Act.

''(B) The term 'Medicaid program' means the program of medical assistance under title XIX of such Act.

''(C) The term 'SCHIP' means the State children's health insurance program under title XXI of such Act.

''(e) PAYMENTS AND CLAIMS ADMINISTRATION.—

''(1) PAYMENT AMOUNT.—The amount of payment under this section to a provider for emergency health care services shall be equal to 100 percent of the payment rate for the corresponding service under part A or B of the Medicare program, or, in the case of prescription drugs and other items and services not covered under either such part, such amount as the Secretary may specify by rule. Such a provider shall not be permitted to impose any cost-sharing or to balance bill for services furnished under this section.

''(2) USE OF MEDICARE CONTRACTORS.—The Secretary shall enter into arrangements with Medicare administrative contractors under which such contractors process claims for emergency health care services under this section using the claim forms, codes, and nomenclature in effect under the Medicare program.

''(3) APPLICATION OF SECONDARY PAYER RULES.—In the case of payment under this section for emergency health care services for otherwise qualified individuals who have some health insurance coverage with respect to such services, the administrative contractors under paragraph (2) shall submit a claim to the entity offering such coverage to recoup all or some of such payment, reflecting whatever amount the entity would normally reimburse for each covered service. The provisions of section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) shall apply to benefits provided under this section in the same manner as they apply to benefits provided under the Medicare program.

''(4) PAYMENTS FOR EMERGENCY HEALTH CARE SERVICES AND RELATED COSTS.—Payments to provide, and costs to administer, emergency health care services under this section shall be made from the Public Health Emergency Fund, as provided under subsection (f)(1).

''(5) ATTESTATION REQUIREMENT.—No payment shall be made under this section to a provider for emergency health care services unless the provider has executed an attestation that—

''(A) the provider has notified the administrative contractor of any third-party payment received or claims pending for such services;

''(B) the recipient of the services has executed an attestation or otherwise satisfies the eligibility criteria established under subsection (b); and

''(C) the services were medically necessary.

''(f) PUBLIC HEALTH EMERGENCY FUND; FRAUD AND ABUSE PROVISIONS.—

''(1) THE PUBLIC HEALTH EMERGENCY FUND.—There is authorized to be appropriated to the Public Health Emergency Fund (established under section 319(b)) such sums as may be necessary under this section for payments to provide emergency health care services and costs to administer the services during a public health emergency.

''(2) NO USE OF MEDICARE FUNDS.—No funds under the Medicare program shall be made available or used to make payments under this section.

''(3) FRAUD AND ABUSE PROVISIONS.—Providers and recipients of emergency health care services under this section shall be subject to the Federal fraud and abuse protections that apply to Federal health care programs as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)).

''(g) RULEMAKING.—The Secretary may issue regulations to carry out this section and shall use a negotiated rulemaking process to advise the Secretary on key issues regarding the implementation of this section.

''(h) PUBLIC HEALTH EMERGENCY PLANNING AND THE EDUCATION OF HEALTH CARE PROVIDERS AND THE GENERAL POPULATION.—

''(1) PLANNING FOR COVERAGE OF EMERGENCY HEALTH CARE SERVICES IN PUBLIC HEALTH EMERGENCIES.—The Secretary shall, not later than 90 days after the date of the enactment of this section, initiate planning to carry out this section, including planning relating to implementation of the payments and claims administration under subsection (e), in the event of activation of emergency health care coverage.

''(2) OUTREACH AND PUBLIC EDUCATION CAMPAIGN.—The Secretary shall conduct an outreach and public education campaign to inform health care providers and the general public about the availability of emergency health care coverage under this section during the period of the emergency. Such campaign shall include—

''(A) an explanation of the emergency health care coverage program under this section;

''(B) claim forms and instructions for health care providers to use when providing covered services during the emergency period; and

''(C) special outreach initiatives to vulnerable and hard-to-reach populations.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each fiscal year (beginning with fiscal year 2009) $7,000,000 to carry out paragraphs (1) and (2) during the fiscal year.

''(i) APPLICATION OF POLICIES UNDER OTHER FEDERAL HEALTH CARE PROGRAMS.—As specified in subsections (c) through (e), the Secretary may adopt in whole or in part the coverage, reimbursement, provider enrollment, and other policies used under the Medicare program and other Federal health care programs in administering emergency health care services under this section to the extent consistent with this section.''.

(b) APPLICATION OF PUBLIC HEALTH EMERGENCY FUND.—Section 319(b)(1) of such Act (42 U.S.C. 247d(b)(1)) is amended—

(1) by inserting ''and section 319K–1'' after ''subsection (a)''; and

(2) by striking ''such subsection'' and inserting ''subsection (a)''.

By Mr. ROCKEFELLER (for himself, Mr. CASEY, and Mrs. GILLIBRAND):

S. 958. A bill to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2009; to the Committee on Finance.

Mr. ROCKEFELLER, Mr. President, I rise today, with my colleagues, Senator GILLIBRAND and Senator CASEY, to reintroduce an important piece of legislation—the MediKids Health Insurance Act of 2009. This legislation will finish the job we started with CHIP reauthorization by providing health care coverage for every child in the U.S. by 2015, regardless of family income.

Congressman STARK and I have introduced our MediKids legislation in each of the last five Congresses because we know how vital health insurance is to a child. Year after year, study after study has shown that uninsured children are more likely to have unmet health care needs. Without adequate health care, childhood illnesses are more likely to turn into chronic conditions in adulthood with debilitating effects. Even something as simple as an ear infection, if left untreated, can cause hearing loss, which can hinder a child's speech and language development. Furthermore, children with unmet health care needs often underperform in the classroom and miss more days of school. Less time in school means students can struggle to develop the skills necessary to become productive members of society.

Despite the well-documented benefits of providing health insurance coverage for children, according to the Kaiser Family Foundation, there were over 9 million uninsured children in America in 2007. A significant step forward in providing health insurance for our uninsured children was the reauthorization of the Children's Health Insurance Program, a bill I coauthored. Expansions in Medicaid and the Children's Health Insurance Program have helped reduce the percentage of low-income children that are uninsured from 28

percent to 15 percent since 1997, with another significant reduction probable after the 2009 CHIP reauthorization legislation is fully implemented. As pleased as I was with the reauthorization of this vital program, it is estimated that millions of children will still remain uninsured. This is unacceptable. We must provide universal coverage for children.

Children are entirely reliant on others to care for them. They cannot go out and purchase their own health insurance. Just as Congress provides for the care of the other segment of our population that is heavily reliant on others, the elderly through Medicare, the time has come to make certain that all children also have access to comprehensive health care. Healthy, well educated children are the key to the future success of our country and we cannot allow them to continue to fall through the cracks. Now, more than ever, it is time to finally pass the MediKids Health Insurance Act.

This legislation is a clear investment in our future—our children. Every child would be automatically enrolled at birth into a new, comprehensive, Federal safety net health insurance program beginning in 2010 and would be eligible up to age 23. The benefits would be tailored to meet the needs of children and would be similar to those currently available to children through the Medicaid Early and Periodic Screening, Diagnosis, and Treatment, EPSDT, program.

Families below 150 percent of poverty would pay no premiums or co-payments, while those between 150 and 300 percent of poverty would pay graduated premiums up to 5 percent of income and a graduated refundable tax credit for cost-sharing. Families above 300 percent of poverty would pay a small premium equivalent to one fourth of the average annual cost per child. There would be no cost sharing for preventive or well-child visits for any child.

MediKids children would remain enrolled in the program throughout childhood. When families move to another state, MediKids would be available until parents enroll their children in a new insurance program. Between jobs or during family crises, MediKids would offer extra security and ensure continuous health coverage to our nation's children. During the critical period when a family climbs out of poverty and out of the eligibility range for means-tested assistance programs, MediKids would fill in the gaps as parents move into jobs that provide reliable health insurance coverage. Our program rests on the premise that whenever other sources of health insurance fail, MediKids would stand ready to cover the health needs of our next generation. Ultimately, every child in America would grow up with consistent, continuous health insurance coverage.

Congress cannot rest on the success we achieved by reauthorizing the Children's Health Insurance Program. Although CHIP was a remarkable step toward reducing the ranks of uninsured children, there is still much more work to be done. The MediKids Health Insurance Act is a comprehensive approach toward eliminating the damaging lack of health insurance for so many children in our country, and I urge my colleagues to support this legislation.

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

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

S. 958

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''MediKids Health Insurance Act of 2009''.

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

(c) FINDINGS.—Congress finds the following:

(1) More than 9 million American children are uninsured.

(2) Children who are uninsured receive less medical care and less preventive care and have a poorer level of health, which result in lifetime costs to themselves and to the entire American economy.

(3) Although CHIP and Medicaid are successfully extending a health coverage safety net to a growing portion of the vulnerable low-income population of uninsured children, they alone cannot achieve 100 percent health insurance coverage for our nation's children due to inevitable gaps during outreach and enrollment, fluctuations in eligibility, variations in access to private insurance at all income levels, and variations in States' ability to provide required matching funds.

(4) As all segments of society continue to become more transient, with many changes in employment over the working lifetime of parents, the need for a reliable safety net of health insurance which follows children across State lines, already a major problem for the children of migrant and seasonal farmworkers, will become a major concern for all families in the United States.

(5) The medicare program has successfully evolved over the years to provide a stable, universal source of health insurance for the nation's disabled and those over age 65, and provides a tested model for designing a program to reach out to America's children.

(6) The problem of insuring 100 percent of all American children could be gradually solved by automatically enrolling all children born after December 31, 2009, in a program modeled after Medicare (and to be known as ''MediKids''), and allowing those children to be transferred into other equivalent or better insurance programs, including either private insurance, CHIP, or Medicaid, if they are eligible to do so, but maintaining the child's default enrollment in MediKids for any times when the child's access to other sources of insurance is lost.

(7) A family's freedom of choice to use other insurers to cover children would not be interfered with in any way, and children eligible for CHIP and Medicaid would continue to be enrolled in those programs, but the underlying safety net of MediKids would always be available to cover any gaps in insurance due to changes in medical condition, employment, income, or marital status, or other changes affecting a child's access to alternate forms of insurance.

(8) The MediKids program can be administered without impacting the finances or status of the existing Medicare program.

(9) The MediKids benefit package can be tailored to the special needs of children and updated over time.

(10) The financing of the program can be administered without difficulty by a yearly payment of affordable premiums through a family's tax filing (or adjustment of a family's earned income tax credit).

(11) The cost of the program will gradually rise as the number of children using MediKids as the insurer of last resort increases, and a future Congress always can accelerate or slow down the enrollment process as desired, while the societal costs for emergency room usage, lost productivity and work days, and poor health status for the next generation of Americans will decline.

(12) Over time 100 percent of American children will always have basic health insurance, and we can therefore expect a healthier, more equitable, and more productive society.

SEC. 2. BENEFITS FOR ALL CHILDREN BORN AFTER 2009.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXII—MEDIKIDS PROGRAM

''SEC. 2201. ELIGIBILITY.

''(a) ELIGIBILITY OF INDIVIDUALS BORN AFTER DECEMBER 31, 2009; ALL CHILDREN UNDER 23 YEARS OF AGE IN FIFTH YEAR.—An individual who meets the following requirements with respect to a month is eligible to enroll under this title with respect to such month:

''(1) AGE.—

''(A) FIRST YEAR.—As of the first day of the first year in which this title is effective, the individual has not attained 6 years of age.

''(B) SECOND YEAR.—As of the first day of the second year in which this title is effective, the individual has not attained 11 years of age.

''(C) THIRD YEAR.—As of the first day of the third year in which this title is effective, the individual has not attained 16 years of age.

''(D) FOURTH YEAR.—As of the first day of the fourth year in which this title is effective, the individual has not attained 21 years of age.

''(E) FIFTH AND SUBSEQUENT YEARS.—As of the first day of the fifth year in which this title is effective and each subsequent year, the individual has not attained 23 years of age.

''(2) CITIZENSHIP.—The individual is a citizen or national of the United States or is permanently residing in the United States under color of law.

''(b) ENROLLMENT PROCESS.—An individual may enroll in the program established under this title only in such manner and form as may be prescribed by regulations, and only

during an enrollment period prescribed by the Secretary consistent with the provisions of this section. Such regulations shall provide a process under which—

''(1) individuals who are born in the United States after December 31, 2009, are deemed to be enrolled at the time of birth and a parent or guardian of such an individual is permitted to pre-enroll in the month prior to the expected month of birth;

''(2) individuals who are born outside the United States after such date and who become eligible to enroll by virtue of immigration into (or an adjustment of immigration status in) the United States are deemed enrolled at the time of entry or adjustment of status;

''(3) eligible individuals may otherwise be enrolled at such other times and manner as the Secretary shall specify, including the use of outstationed eligibility sites as described in section 1902(a)(55)(A) and the use of presumptive eligibility provisions like those described in section 1920A; and

''(4) at the time of automatic enrollment of a child, the Secretary provides for issuance to a parent or custodian of the individual a card evidencing coverage under this title and for a description of such coverage.

The provisions of section 1837(h) apply with respect to enrollment under this title in the same manner as they apply to enrollment under part B of title XVIII. An individual who is enrolled under this title is not eligible to be enrolled under an MA or MA–PD plan under part C of title XVIII.

''(c) DATE COVERAGE BEGINS.—

''(1) IN GENERAL.—The period during which an individual is entitled to benefits under this title shall begin as follows, but in no case earlier than January 1, 2010:

''(A) In the case of an individual who is enrolled under paragraph (1) or (2) of subsection (b), the date of birth or date of obtaining appropriate citizenship or immigration status, as the case may be.

''(B) In the case of another individual who enrolls (including pre-enrolls) before the month in which the individual satisfies eligibility for enrollment under subsection (a), the first day of such month of eligibility.

''(C) In the case of another individual who enrolls during or after the month in which the individual first satisfies eligibility for enrollment under such subsection, the first day of the following month.

''(2) AUTHORITY TO PROVIDE FOR PARTIAL MONTHS OF COVERAGE.—Under regulations, the Secretary may, in the Secretary's discretion, provide for coverage periods that include portions of a month in order to avoid lapses of coverage.

''(3) LIMITATION ON PAYMENTS.—No payments may be made under this title with respect to the expenses of an individual enrolled under this title unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

''(d) EXPIRATION OF ELIGIBILITY.—An individual's coverage period under this section shall continue until the individual's enrollment has been terminated because the individual no longer meets the requirements of subsection (a) (whether because of age or change in immigration status).

''(e) ENTITLEMENT TO MEDIKIDS BENEFITS FOR ENROLLED INDIVIDUALS.—An individual enrolled under this title is entitled to the benefits described in section 2202.

''(f) LOW-INCOME INFORMATION.—

''(1) INQUIRY OF INCOME.—At the time of enrollment of a child under this title, the Secretary shall make an inquiry as to whether the family income (as determined for purposes of section 1905(p)) of the family that includes the child is within any of the following income ranges:

''(A) UP TO 150 PERCENT OF POVERTY.—The income of the family does not exceed 150 percent of the poverty line for a family of the size involved.

''(B) BETWEEN 150 AND 200 PERCENT OF POVERTY.—The income of the family exceeds 150 percent, but does not exceed 200 percent, of such poverty line.

''(C) BETWEEN 200 AND 300 PERCENT OF POVERTY.—The income of the family exceeds 200 percent, but does not exceed 300 percent, of such poverty line.

''(2) CODING.—If the family income is within a range described in paragraph (1), the Secretary shall encode in the identification card issued in connection with eligibility under this title a code indicating the range applicable to the family of the child involved.

''(3) PROVIDER VERIFICATION THROUGH ELECTRONIC SYSTEM.—The Secretary also shall provide for an electronic system through which providers may verify which income range described in paragraph (1), if any, is applicable to the family of the child involved.

''(g) CONSTRUCTION.—Nothing in this title shall be construed as requiring (or preventing) an individual who is enrolled under this title from seeking medical assistance under a State medicaid plan under title XIX or child health assistance under a State child health plan under title XXI.

''SEC. 2202. BENEFITS.

''(a) SECRETARIAL SPECIFICATION OF BENEFIT PACKAGE.—

''(1) IN GENERAL.—The Secretary shall specify the benefits to be made available under this title consistent with the provisions of this section and in a manner designed to meet the health needs of enrollees.

''(2) UPDATING.—The Secretary shall update the specification of benefits over time to ensure the inclusion of age-appropriate benefits to reflect the enrollee population.

''(3) ANNUAL UPDATING.—The Secretary shall establish procedures for the annual review and updating of such benefits to account for changes in medical practice, new information from medical research, and other relevant developments in health science.

''(4) INPUT.—The Secretary shall seek the input of the pediatric community in specifying and updating such benefits.

''(5) LIMITATION ON UPDATING.—In no case shall updating of benefits under this subsection result in a failure to provide benefits required under subsection (b).

''(b) INCLUSION OF CERTAIN BENEFITS.—

''(1) MEDICARE CORE BENEFITS.—Such benefits shall include (to the extent consistent with other provisions of this section) at least the same benefits (including coverage, access, availability, duration, and beneficiary rights) that are available under parts A and B of title XVIII.

''(2) ALL REQUIRED MEDICAID BENEFITS.—Such benefits shall also include all items and services for which medical assistance is required to be provided under section 1902(a)(10)(A) to individuals described in such section, including early and periodic screening, diagnostic services, and treatment services.

''(3) INCLUSION OF PRESCRIPTION DRUGS.—Such benefits also shall include (as specified by the Secretary) benefits for prescription drugs and biologicals which are not less than the benefits for such drugs and biologicals under the standard option for the service benefit plan described in section 8903(1) of title 5, United States Code, offered during 2008.

''(4) COST-SHARING.—

''(A) IN GENERAL.—Subject to subparagraph (B), such benefits also shall include the cost-sharing (in the form of deductibles, coinsurance, and copayments) which is substantially similar to such cost-sharing under the health benefits coverage in any of the four largest health benefits plans (determined by enrollment) offered under chapter 89 of title 5, United States Code, and including an out-of-pocket limit for catastrophic expenditures for covered benefits, except that no cost-sharing shall be imposed with respect to early and periodic screening and diagnostic services included under paragraph (2).

''(B) REDUCED COST-SHARING FOR LOW INCOME CHILDREN.—Such benefits shall provide that—

''(i) there shall be no cost-sharing for children in families the income of which is within the range described in section 2201(f)(1)(A);

''(ii) the cost-sharing otherwise applicable shall be reduced by 75 percent for children in families the income of which is within the range described in section 2201(f)(1)(B); or

''(iii) the cost-sharing otherwise applicable shall be reduced by 50 percent for children in families the income of which is within the range described in section 2201(f)(1)(C).

''(C) CATASTROPHIC LIMIT ON COST-SHARING.—For a refundable credit for cost-sharing in the case of cost-sharing in excess of a percentage of the individual's adjusted gross income, see section 36 of the Internal Revenue Code of 1986.

''(c) PAYMENT SCHEDULE.—The Secretary, with the assistance of the Medicare Payment Advisory Commission, shall develop and implement a payment schedule for benefits covered under this title. To the extent feasible, such payment schedule shall be consistent with comparable payment schedules and reimbursement methodologies applied under parts A and B of title XVIII.

''(d) INPUT.—The Secretary shall specify such benefits and payment schedules only after obtaining input from appropriate child health providers and experts.

''(e) ENROLLMENT IN HEALTH PLANS.—The Secretary shall provide for the offering of benefits under this title through enrollment in a health benefit plan that meets the same (or similar) requirements as the requirements that apply to Medicare Advantage plans under part C of title XVIII (other than any such requirements that relate to part D of such title). In the case of individuals enrolled under this title in such a plan, the payment rate shall be based on payment rates provided for under section 1853(c) in effect before the date of the enactment of the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (Public Law 108–173), except that such payment rates shall be adjusted in an appropriate manner to reflect differences between the population served under this title and the population under title XVIII.

''SEC. 2203. PREMIUMS.

''(a) AMOUNT OF MONTHLY PREMIUMS.—

''(1) IN GENERAL.—The Secretary shall, during September of each year (beginning with 2009), establish a monthly MediKids premium for the following year. Subject to paragraph (2), the monthly MediKids premium for a year is equal to 1/12 of the annual premium rate computed under subsection (b).

''(2) ELIMINATION OF MONTHLY PREMIUM FOR DEMONSTRATION OF EQUIVALENT COVERAGE (INCLUDING COVERAGE UNDER LOW-INCOME PROGRAMS).—The amount of the monthly premium imposed under this section for an individual for a month shall be zero in the case of an individual who demonstrates to the satisfaction of the Secretary that the individual has basic health insurance coverage for that month. For purposes of the previous sentence enrollment in a medicaid plan under title XIX, a State child health insurance plan under title XXI, or under the medicare program under title XVIII is deemed to

constitute basic health insurance coverage described in such sentence.

''(b) ANNUAL PREMIUM.—

''(1) NATIONAL PER CAPITA AVERAGE.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 2201(a)(1) as if all such individuals were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

''(2) ANNUAL PREMIUM.—Subject to subsection (d), the annual premium under this subsection for months in a year is equal to 25 percent of the average, annual per capita amount estimated under paragraph (1) for the year.

''(c) PAYMENT OF MONTHLY PREMIUM.—

''(1) PERIOD OF PAYMENT.—In the case of an individual who participates in the program established by this title, subject to subsection (d), the monthly premium shall be payable for the period commencing with the first month of the individual's coverage period and ending with the month in which the individual's coverage under this title terminates.

''(2) COLLECTION THROUGH TAX RETURN.—For provisions providing for the payment of monthly premiums under this subsection, see section 59B of the Internal Revenue Code of 1986.

''(3) PROTECTIONS AGAINST FRAUD AND ABUSE.—The Secretary shall develop, in coordination with States and other health insurance issuers, administrative systems to ensure that claims which are submitted to more than one payor are coordinated and duplicate payments are not made.

''(d) REDUCTION IN PREMIUM FOR CERTAIN LOW-INCOME FAMILIES.—For provisions reducing the premium under this section for certain low-income families, see section 59B(d) of the Internal Revenue Code of 1986.

''SEC. 2204. MEDIKIDS TRUST FUND.

''(a) ESTABLISHMENT OF TRUST FUND.—

''(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'MediKids Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

''(2) PREMIUMS.—Premiums collected under section 59B of the Internal Revenue Code of 1986 shall be periodically transferred to the Trust Fund.

''(3) TRANSITIONAL FUNDING BEFORE RECEIPT OF PREMIUMS.—In order to provide for funds in the Trust Fund to cover expenditures from the fund in advance of receipt of premiums under section 2203, there are transferred to the Trust Fund from the general fund of the United States Treasury such amounts as may be necessary.

''(b) INCORPORATION OF PROVISIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), subsection (b) (other than the last sentence) and subsections (c) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively.

''(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1841 under paragraph (1)—

''(A) any reference in such section to 'this part' is construed to refer to title XXII;

''(B) any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed references to comparable authority exercised under this title;

''(C) payments may be made under section 1841(g) to the Trust Funds under sections 1817 and 1841 as reimbursement to such funds for payments they made for benefits provided under this title; and

''(D) the Board of Trustees of the MediKids Trust Fund shall be the same as the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

''SEC. 2205. OVERSIGHT AND ACCOUNTABILITY.

''(a) PERIODIC GAO REPORTS.—The Comptroller General of the United States shall periodically submit to Congress reports on the operation of the program under this title, including on the financing of coverage provided under this title.

''(b) PERIODIC MACPAC REPORTS.—The Medicaid and CHIP Payment and Access Commission shall periodically report to Congress concerning the program under this title.

''SEC. 2206. INCLUSION OF CARE COORDINATION SERVICES.

''(a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2010, may implement a care coordination services program in accordance with the provisions of this section under which, in appropriate circumstances, eligible individuals under section 2201 may elect to have health care services covered under this title managed and coordinated by a designated care coordinator.

''(2) ADMINISTRATION BY CONTRACT.—The Secretary may administer the program under this section through a contract with an appropriate program administrator.

''(3) COVERAGE.—Care coordination services furnished in accordance with this section shall be treated under this title as if they were included in the definition of medical and other health services under section 1861(s) and benefits shall be available under this title with respect to such services without the application of any deductible or coinsurance.

''(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

''(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in the care coordination services program under this section, which shall include at least a finding by the Secretary that for cohorts of individuals with characteristics identified by the Secretary, professional management and coordination of care can reasonably be expected to improve processes or outcomes of health care and to reduce aggregate costs to the programs under this title.

''(2) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section.

''(c) ENROLLMENT OF INDIVIDUALS.—

''(1) SECRETARY'S DETERMINATION OF ELIGIBILITY.—The Secretary shall determine the eligibility for services under this section of individuals who are enrolled in the program under this section and who make application for such services in such form and manner as the Secretary may prescribe.

''(2) ENROLLMENT PERIOD.—

''(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for one month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation. Such procedures shall permit an individual to disenroll for cause at any time and without cause at re-enrollment intervals.

''(B) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

''(d) PROGRAM.—The care coordination services program under this section shall include the following elements:

''(1) BASIC CARE COORDINATION SERVICES.—

''(A) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1), except as otherwise provided in this section, enrolled individuals shall receive services described in section 1905(t)(1) and may receive additional items and services as described in subparagraph (B).

''(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to individuals enrolled in the program under this section (subject to an assessment by the care coordinator of an individual's circumstance and need for such benefits) in order to encourage enrollment in, or to improve the effectiveness of, such program.

''(2) CARE COORDINATION REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the care coordinator, or coordinated through the care coordination services program. Under such provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(e) CARE COORDINATORS.—

''(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination services under this section, an individual or entity shall—

''(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

''(B) have entered into a care coordination agreement; and

''(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

''(2) AGREEMENT TERM; PAYMENT.—

''(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall be for one year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1).

''(B) PAYMENT FOR SERVICES.—The Secretary may negotiate or otherwise establish payment terms and rates for services described in subsection (d)(1).

''(C) LIABILITY.—Care coordinators shall be subject to liability for actual health damages which may be suffered by recipients as a result of the care coordinator's decisions, failure or delay in making decisions, or other actions as a care coordinator.

''(D) TERMS.—In addition to such other terms as the Secretary may require, an agreement under this section shall include the terms specified in subparagraphs (A) through (C) of section 1905(t)(3).

''SEC. 2207. ADMINISTRATION AND MISCELLANEOUS.

''(a) IN GENERAL.—Except as otherwise provided in this title—

''(1) the Secretary shall enter into appropriate contracts with providers of services, other health care providers, carriers, and fiscal intermediaries, taking into account the types of contracts used under title XVIII with respect to such entities, to administer the program under this title;

''(2) beneficiary protections for individuals enrolled under this title shall not be less than the beneficiary protections (including limits on balance billing) provided medicare beneficiaries under title XVIII;

''(3) benefits described in section 2202 that are payable under this title to such individuals shall be paid in a manner specified by the Secretary (taking into account, and based to the greatest extent practicable upon, the manner in which they are provided under title XVIII); and

''(4) provider participation agreements under title XVIII shall apply to enrollees and benefits under this title in the same manner as they apply to enrollees and benefits under title XVIII.

''(b) COORDINATION WITH MEDICAID AND CHIP.—Notwithstanding any other provision of law, individuals entitled to benefits for items and services under this title who also qualify for benefits under title XIX or XXI or any other Federally funded health care program that provides basic health insurance coverage described in section 2203(a)(2) may continue to qualify and obtain benefits under such other title or program, and in such case such an individual shall elect either—

''(1) such other title or program to be primary payor to benefits under this title, in which case no benefits shall be payable under this title and the monthly premium under section 2203 shall be zero; or

''(2) benefits under this title shall be primary payor to benefits provided under such title or program, in which case the Secretary shall enter into agreements with States as may be appropriate to provide that, in the case of such individuals, the benefits under titles XIX and XXI or such other program (including reduction of cost-sharing) are provided on a 'wrap-around' basis to the benefits under this title.''.

(b) CONFORMING AMENDMENTS TO SOCIAL SECURITY ACT PROVISIONS.—

(1) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended by striking ''or the Federal Supplementary Medical Insurance Trust Fund'' and inserting ''the Federal Supplementary Medical Insurance Trust Fund, and the MediKids Trust Fund''.

(2) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking ''and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII'' and inserting '', the Federal Supplementary Medical Insurance Trust Fund, and the MediKids Trust Fund established by title XVIII''.

(c) MAINTENANCE OF MEDICAID ELIGIBILITY AND BENEFITS FOR CHILDREN.—

(1) IN GENERAL.—In order for a State to continue to be eligible for payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))—

(A) the State may not reduce standards of eligibility, or benefits, provided under its State medicaid plan under title XIX of the Social Security Act or under its State child health plan under title XXI of such Act for individuals under 23 years of age below such standards of eligibility, and benefits, in effect on the date of the enactment of this Act; and

(B) the State shall demonstrate to the satisfaction of the Secretary of Health and Human Services that any savings in State expenditures under title XIX or XXI of the Social Security Act that results from children enrolling under title XXII of such Act shall be used in a manner that improves services to beneficiaries under title XIX of such Act, such as through expansion of eligibility, improved nurse and nurse aide staffing and improved inspections of nursing facilities, and coverage of additional services.

(2) MEDIKIDS AS PRIMARY PAYOR.—In applying title XIX of the Social Security Act, the MediKids program under title XXII of such Act shall be treated as a primary payor in cases in which the election described in section 2207(b)(2) of such Act, as added by subsection (a), has been made.

(d) EXPANSION OF MACPAC DUTIES.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)(1)(A)—

(A) by striking ''and the State'' and inserting '', the State''; and

(B) by inserting ''and the MediKids program established under title XXII (in this section referred to as 'MediKids')'' before ''affecting''; and

(2) by striking ''and CHIP'' each place it appears (other than in subsection (a)) and inserting '', CHIP, and MediKids''.

SEC. 3. MEDIKIDS PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end the following new part:

''PART VIII—MEDIKIDS PREMIUM

''Sec. 59B. MediKids premium.

''SEC. 59B. MEDIKIDS PREMIUM.

''(a) IMPOSITION OF TAX.—In the case of a taxpayer to whom this section applies, there is hereby imposed (in addition to any other tax imposed by this subtitle) a MediKids premium for the taxable year.

''(b) INDIVIDUALS SUBJECT TO PREMIUM.—

''(1) IN GENERAL.—This section shall apply to a taxpayer if a MediKid is a dependent of the taxpayer for the taxable year.

''(2) MEDIKID.—For purposes of this section, the term 'MediKid' means any individual enrolled in the MediKids program under title XXII of the Social Security Act.

''(c) AMOUNT OF PREMIUM.—For purposes of this section, the MediKids premium for a taxable year is the sum of the monthly premiums (for months in the taxable year) determined under section 2203 of the Social Security Act with respect to each MediKid who is a dependent of the taxpayer for the taxable year.

''(d) EXCEPTIONS BASED ON ADJUSTED GROSS INCOME.—

''(1) EXEMPTION FOR VERY LOW-INCOME TAXPAYERS.—

''(A) IN GENERAL.—No premium shall be imposed by this section on any taxpayer having an adjusted gross income not in excess of the exemption amount.

''(B) EXEMPTION AMOUNT.—For purposes of this paragraph, the exemption amount is—

''(i) $20,535 in the case of a taxpayer having 1 MediKid,

''(ii) $25,755 in the case of a taxpayer having 2 MediKids,

''(iii) $30,975 in the case of a taxpayer having 3 MediKids, and

''(iv) $35,195 in the case of a taxpayer having 4 or more MediKids.

''(C) PHASEOUT OF EXEMPTION.—In the case of a taxpayer having an adjusted gross income which exceeds the exemption amount but does not exceed twice the exemption amount, the premium shall be the amount which bears the same ratio to the premium which would (but for this subparagraph) apply to the taxpayer as such excess bears to the exemption amount.

''(D) INFLATION ADJUSTMENT OF EXEMPTION AMOUNTS.—In the case of any taxable year beginning in a calendar year after 2010, each dollar amount contained in subparagraph (C) shall be increased by an amount equal to the product of—

''(i) such dollar amount, and

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(2) PREMIUM LIMITED TO 5 PERCENT OF ADJUSTED GROSS INCOME.—In no event shall any taxpayer be required to pay a premium under this section in excess of an amount equal to 5 percent of the taxpayer's adjusted gross income.

''(e) COORDINATION WITH OTHER PROVISIONS.—

''(1) NOT TREATED AS MEDICAL EXPENSE.—For purposes of this chapter, any premium paid under this section shall not be treated as expense for medical care.

''(2) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium paid under this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(A) the amount of any credit allowable under this chapter, or

''(B) the amount of the minimum tax imposed by section 55.

''(3) TREATMENT UNDER SUBTITLE F.—For purposes of subtitle F, the premium paid under this section shall be treated as if it were a tax imposed by section 1.''.

(b) TECHNICAL AMENDMENTS.—

(1) Subsection (a) of section 6012 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (9) the following new paragraph:

''(10) Every individual liable for a premium under section 59B.''.

(2) The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end the following new item:

''PART VIII. MEDIKIDS PREMIUM''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 2009, in taxable years ending after such date.

SEC. 4. REFUNDABLE CREDIT FOR CERTAIN COST-SHARING EXPENSES UNDER MEDIKIDS PROGRAM.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

''SEC. 36B. CATASTROPHIC LIMIT ON COST-SHARING EXPENSES UNDER MEDIKIDS PROGRAM.

''(a) IN GENERAL.—In the case of a taxpayer who has a MediKid (as defined in section 59B) at any time during the taxable year, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the excess of—

''(1) the amount paid by the taxpayer during the taxable year as cost-sharing under section 2202(b)(4) of the Social Security Act, over

''(2) 5 percent of the taxpayer's adjusted gross income for the taxable year.

''(b) COORDINATION WITH OTHER PROVISIONS.—The excess described in subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).''.

(b) TECHNICAL AMENDMENTS.—

(1) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by

inserting after the item relating to section 36A the following new item:

''Sec. 36B. Catastrophic limit on cost-sharing expenses under MediKids program.''.

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

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

SEC. 5. REPORT ON LONG-TERM REVENUES.

Within one year after the date of the enactment of this Act, the Secretary of the Treasury shall propose a gradual schedule of progressive tax changes to fund the program under title XXII of the Social Security Act, as the number of enrollees grows in the outyears.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 125—IN SUPPORT AND RECOGNITION OF NATIONAL TRAIN DAY, MAY 9, 2009

Mr. LAUTENBERG (for himself, Mr. ROCKEFELLER, Mrs. HUTCHISON, Mr. THUNE, Mr. DORGAN, Mrs. BOXER, Mr. WHITEHOUSE, Mr. WARNER, Mr. KERRY, Mr. DURBIN, Mr. SPECTER, Mr. SCHUMER, Mr. BAYH, Mr. UDALL, of New Mexico; Mr. BROWN, Mr. CARPER, and Mr. LIEBERMAN) submitted the following resolution; which was referred to the Committee on Commerce, Science, and Transportation:

S. RES. 125

Whereas, in May 1869 the ''golden spike'' was driven into the final tie at Promontory Summit, Utah to join the Central Pacific and the Union Pacific Railroads, ceremonially completing the first transcontinental railroad and therefore connecting both coasts of the United States;

Whereas, Amtrak trains and infrastructure carry commuters to and from work in congested metropolitan areas providing a reliable rail option and reducing congestion on roads and in the skies;

Whereas, for many rural Americans, Amtrak represents the only major intercity transportation link to the rest of the country;

Whereas, passenger trains provide a more fuel-efficient transportation system thereby providing cleaner transportation alternatives and energy security;

Whereas, intercity passenger rail was 18 percent more energy efficient than airplanes and 25 percent more energy efficient than automobiles on a per-passenger-mile basis in 2006;

Whereas, Amtrak annually provides intercity passenger rail travel to over 28 million Americans residing in 46 states;

Whereas, an increasing number of people are using trains for travel purposes beyond commuting to and from work; and

Whereas, community railroad stations are a source of civic pride, a gateway to over 500 of our nation's communities, and a tool for economic growth: Now, therefore, be it

Resolved, That the Senate supports the goals and ideals of National Train Day, as designated by Amtrak.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1030. Mr. THUNE submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, to prevent mortgage foreclosures and enhance mortgage credit availability; which was ordered to lie on the table.

SA 1031. Mr. SCHUMER submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr . SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1032. Mr. FEINGOLD (for himself and Mrs. GILLIBRAND) submitted an amendment intended to be proposed by him to the bill S. 896, supra; which was ordered to lie on the table.

SA 1033. Mr. CASEY (for himself, Mr. LEAHY, Mr. SPECTER, and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1034. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1035. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1036. Mr. KERRY (for himself, Mrs. GILLIBRAND, Mr. REID, Mr. DODD, and Mr. KENNEDY) submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1037. Mr. KOHL submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1038. Mrs. BOXER (for herself and Mr. REID) submitted an amendment intended to be proposed by her to the bill S. 896, supra; which was ordered to lie on the table.

SA 1039. Mr. REED (for himself and Mr. VITTER) submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1040. Mr. REED (for himself and Mr. BOND) submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

SA 1041. Mr. REED submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1030. Mr. THUNE submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, to prevent mortgage foreclosures and enhance mortgage credit availability; which was ordered to lie on the table; as follows:

At the end of the amendment, add the following:

TITLE V—TARP REDUCTION PRIORITY ACT

SEC. 501. SHORT TITLE.

This title may be cited as the ''TARP Reduction Priority Act''.

SEC. 502. FINDINGS.

Congress finds the following:

(1) On October 7, 2008, Congress established the Troubled Assets Relief Program (TARP) as part of the Emergency Economic Stabilization Act (Public 110-343; 122 Stat. 3765) and allocated $700,000,000,000 for the purchase of toxic assets from banks with the goal of restoring liquidity to the financial sector and restarting the flow of credit in our markets.

(2) The Department of Treasury, without consultation with Congress, changed the purpose of TARP and began injecting capital into financial institutions through a program called the Capital Purchase Program (CPP) rather than purchasing toxic assets.

(3) Lending by financial institutions was not noticeably increased with the implementation of the CPP and the expenditure of $218,000,000,000 of TARP funds, despite the goal of the program.

(4) The recipients of amounts under the CPP are now faced with additional restrictions related to accepting those funds.

(5) A number of community banks and large financial institutions have expressed their desire to return their CPP funds to the Department of Treasury and the Department has begun the process of accepting receipt of such funds.

(6) The Department of the Treasury should not reuse returned funds for additional lending for financial assistance.

(7) The United States Constitution provided Congress with the power of the purse hence any future spending of TARP funds, or other financial assistance, should be determined by Congress.

SEC. 503. TARP AUTHORIZATION REDUCTION.

Section 115(a)(3) the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5211 et seq.) is amended by inserting ''minus any amounts received by the Secretary for repayment of the principal of financial assistance by an entity that has received financial assistance under the TARP or any program enacted by the Secretary under the authorities granted to the Secretary under this Act,'' before ''outstanding at any one time.''

SA 1031. Mr. SCHUMER submitted an amendment intended to be proposed to amendment SA 1018 submitted by Mr. DODD (for himself and Mr. SHELBY) to the bill S. 896, to prevent mortgage foreclosures and enhance mortgage credit availability; which was ordered to lie on the table; as follows:

At the end of title I of the amendment, add the following:

SEC. 105. MULTIFAMILY MORTGAGE RESOLUTION PROGRAM.

Title I of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5211 et seq.) is amended by adding at the end the following:

''SEC. 137. MULTIFAMILY MORTGAGE RESOLUTION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary of the Treasury, in consultation with the Secretary of Housing and Urban Development, shall develop a program to stabilize multifamily properties which are delinquent, at risk of default or disinvestment, or in foreclosure.

''(b) FOCUS OF PROGRAM.—The program developed under this section shall be used to ensure the protection of current and future tenants of at risk multifamily properties by—

''(1) creating sustainable financing of such properties that is based on—

''(A) the current rental income generated by such properties; and

''(B) the preservation of adequate operating reserves;

''(2) maintaining the level of Federal, State, and city subsidies in effect as of the date of enactment of this section; and