bill passed this body over one year ago; the Senate version was adopted in March of this year. Since that time we have been engaged in a lengthy, but extremely productive process with our Senate colleagues and their staff to come together to bridge the differences between the two bills. H.R. 6672 is the product of that effort. It is our hope that the Senate will pass the bill as soon as possible after the House acts on the legislation today, allowing the critical work authorized under the legislation to continue.

Toward that end, H.R. 6672 reauthorizes and makes minor—but important—improvements to various programs and activities first established in the 2004 Project Bioshield Act and the 2006 Pandemic and All-Hazards Preparedness Act, or as it is commonly referred to, ''PAHPA.'' These programs and activities are key in helping to ensure that our Nation is well prepared to successfully manage the effects of natural disasters, infectious disease outbreaks, and acts of bioterrorism.

H.R. 6672 includes dozens of changes to these underlying authorities. Let me highlight just three provisions that deserve special attention:

The bill targets the Food and Drug Administration, FDA, to ensure that it focuses on medical countermeasures—that is, products designed to combat chemical, biological, radioactive, and nuclear agents—of the highest importance. It requires FDA to work with industry on industry-submitted regulatory management plans for prioritized countermeasures to facilitate scientific exchanges between the FDA and countermeasure product sponsors to streamline our ability to make these products available. Just last Friday, FDA approved the first drug developed and procured under Project BioShield. Raxibacumab is approved for use together with antibiotics to treat anthrax in children and adults. The FDA provisions in H.R. 6672—together with the renewed emphasis in our countermeasure enterprise through other provisions in this legislation—will make it possible for even more drugs and devices to move from early development to procurement.

The legislation also makes improvements to the Nation's blueprint for public health preparedness and response activities that will enhance the ability of our diverse health care system to respond to mass casualty emergencies. Among such improvements are clarifying the role of the Assistant Secretary of Preparedness and Response as the lead office within the Department of Health and Human Services, HHS, for emergency preparedness and response. H.R. 6672 also establishes a new authority to permit the HHS Secretary to approve a request of a state, territory, or an Indian tribe to redeploy certain federally-supported employees during the time of a national emergency to geographic areas where such employees are needed most.

In addition, H.R. 6672 continues support for investments in State and local public health departments. Such investments are necessary to make certain that we have the requisite public health infrastructure in place to respond immediately and appropriately to any public health threat that may arise.

This legislation reflects the effort of a number of members—Democrats and Republicans alike. On our side of the aisle Congressman GREEN, Congresswoman ESHOO, Congressman MARKEY, and our Health Subcommittee Ranking Member—Congressman Pallone—have been deeply involved. I want to thank them and their staff for all the long and incredibly hard work they have put into this legislation and to the process of getting us here today.

I urge my colleagues to vote in favor of H.R. 6672.

Mr. PAULSEN. Madam Speaker, I rise in strong support of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2012. This legislation will bolster the nation's public health preparedness infrastructure and ensure the reauthorization of programs that provide key resources to states, health departments and hospitals.

I am particularly pleased that the final legislation contains key provisions that enhance the nation's ability to care for the critically ill and injured in the aftermath of a public health emergency. For the first time, the federal government will be required to prioritize the critical care system in its emergency and disaster planning efforts. Furthermore, the bill requires additional planning regarding evacuation of patients.

Last year, I introduced legislation with my colleague from Wisconsin, Congresswoman BALDWIN to ensure that the nation's critical care system is structured to provide the highest quality and most efficient health care. This legislation is designed to determine inefficiencies in the current system and bolster capabilities to meet future demands—including improving federal disaster preparedness efforts to care for the critically ill or injured.

A key aspect of this bill was to put in place measures to ensure there are sufficient numbers of critical care providers to respond in a medical crisis, develop best practices for the safe evacuation of ICU patients, and enhance the current databases that provide necessary resource information in the aftermath of a disaster. I'm happy to report that these important provisions are all reflected in today's bill.

Today's bill recognizes that critical care services play an important role in our medical response system and provides an opportunity to build more prepared and resilient communities that are able to respond and contain the impact of a public health emergency. I urge its passage.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. ROGERS) that the House suspend the rules and pass the bill, H.R. 6672.

The question was taken.

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

Mr. ROGERS of Michigan. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

PREMATURITY RESEARCH EXPANSION AND EDUCATION FOR MOTHERS WHO DELIVER INFANTS EARLY REAUTHORIZATION ACT

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (S. 1440) to reduce preterm labor and delivery and the risk of pregnancy-related deaths and complications due to pregnancy, and to reduce infant mortality caused by prematurity, as amended.

The Clerk read the title of the bill.

The text of the amendments is as follows:

Amendments:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Prematurity Research Expansion and Education for Mothers who deliver Infants Early Reauthorization Act'' or the ''PREEMIE Reauthorization Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—PREMATURITY RESEARCH EXPANSION AND EDUCATION FOR MOTHERS WHO DELIVER INFANTS EARLY

SEC. 101. RESEARCH AND ACTIVITIES AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) EPIDEMIOLOGICAL STUDIES.—Section 3 of the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act (42 U.S.C. 247b–4f) is amended by striking subsection (b) and inserting the following:

''(b) STUDIES AND ACTIVITIES ON PRETERM BIRTH.—

''(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, may, subject to the availability of appropriations—

''(A) conduct epidemiological studies on the clinical, biological, social, environmental, genetic, and behavioral factors relating to prematurity, as appropriate;

''(B) conduct activities to improve national data to facilitate tracking the burden of preterm birth; and

''(C) continue efforts to prevent preterm birth, including late preterm birth, through the identification of opportunities for prevention and the assessment of the impact of such efforts.

''(2) REPORT.—Not later than 2 years after the date of enactment of the PREEMIE Reauthorization Act, and every 2 years thereafter, the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall submit to the appropriate committees of Congress reports concerning the progress and any results of studies conducted under paragraph (1).''.

(b) REAUTHORIZATION.—Section 3(e) of the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act (42 U.S.C. 247b–4f(e)) is amended by striking ''2011'' and inserting ''2017''.

SEC. 102. ACTIVITIES AT THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(a) TELEMEDICINE AND HIGH-RISK PREGNANCIES.—Section 330I(i)(1)(B) of the Public

Health Service Act (42 U.S.C. 254c–14(i)(1)(B)) is amended by striking ''or case management services'' and inserting ''case management services, or prenatal care for high-risk pregnancies'';

(b) PUBLIC AND HEALTH CARE PROVIDER EDUCATION.—Section 399Q of the Public Health Service Act (42 U.S.C. 280g–5) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking subparagraphs (A) through (F) and inserting the following:

''(A) the core risk factors for preterm labor and delivery;

''(B) medically indicated deliveries before full term;

''(C) the importance of preconception and prenatal care, including—

''(i) smoking cessation;

''(ii) weight maintenance and good nutrition, including folic acid;

''(iii) the screening for and the treatment of infections; and

''(iv) stress management;

''(D) treatments and outcomes for premature infants, including late preterm infants;

''(E) the informational needs of families during the stay of an infant in a neonatal intensive care unit; and

''(F) utilization of evidence-based strategies to prevent birth injuries;''; and

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

''(2) programs to increase the availability, awareness, and use of pregnancy and post-term information services that provide evidence-based, clinical information through counselors, community outreach efforts, electronic or telephonic communication, or other appropriate means regarding causes associated with prematurity, birth defects, or health risks to a post-term infant;''; and

(2) in subsection (c), by striking ''2011'' and inserting ''2017''.

SEC. 103. OTHER ACTIVITIES.

(a) INTERAGENCY COORDINATING COUNCIL ON PREMATURITY AND LOW BIRTHWEIGHT.—The Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act is amended by striking section 5 (42 U.S.C. 247b–4g).

(b) ADVISORY COMMITTEE ON INFANT MORTALITY.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') may establish an advisory committee known as the ''Advisory Committee on Infant Mortality'' (referred to in this section as the ''Advisory Committee'').

(2) DUTIES.—The Advisory Committee shall provide advice and recommendations to the Secretary concerning the following activities:

(A) Programs of the Department of Health and Human Services that are directed at reducing infant mortality and improving the health status of pregnant women and infants.

(B) Strategies to coordinate the various Federal programs and activities with State, local, and private programs and efforts that address factors that affect infant mortality.

(C) Implementation of the Healthy Start program under section 330H of the Public Health Service Act (42 U.S.C. 254c–8) and Healthy People 2020 infant mortality objectives.

(D) Strategies to reduce preterm birth rates through research, programs, and education.

(3) PLAN FOR HHS PRETERM BIRTH ACTIVITIES.—Not later than 1 year after the date of enactment of this section, the Advisory Committee (or an existing advisory committee designated by the Secretary) shall develop a plan for conducting and supporting research, education, and programs on preterm birth through the Department of Health and Human Services and shall periodically review and revise the plan, as appropriate. The plan shall—

(A) examine research and educational activities that receive Federal funding in order to enable the plan to provide informed recommendations to reduce preterm birth and address racial and ethnic disparities in preterm birth rates;

(B) identify research gaps and opportunities to implement evidence-based strategies to reduce preterm birth rates among the programs and activities of the Department of Health and Human Services regarding preterm birth, including opportunities to minimize duplication; and

(C) reflect input from a broad range of scientists, patients, and advocacy groups, as appropriate.

(4) MEMBERSHIP.—The Secretary shall ensure that the membership of the Advisory Committee includes the following:

(A) Representatives provided for in the original charter of the Advisory Committee.

(B) A representative of the National Center for Health Statistics.

(c) PATIENT SAFETY STUDIES AND REPORT.—

(1) IN GENERAL.—The Secretary shall designate an appropriate agency within the Department of Health and Human Services to coordinate existing studies on hospital readmissions of preterm infants.

(2) REPORT TO SECRETARY AND CONGRESS.—Not later than 1 year after the date of the enactment of this Act, the agency designated under paragraph (1) shall submit to the Secretary and to Congress a report containing the findings and recommendations resulting from the studies coordinated under such paragraph, including recommendations for hospital discharge and followup procedures designed to reduce rates of preventable hospital readmissions for preterm infants.

TITLE II—NATIONAL PEDIATRIC RESEARCH NETWORK

SEC. 201. NATIONAL PEDIATRIC RESEARCH NETWORK.

Section 409D of the Public Health Service Act (42 U.S.C. 284h; relating to the Pediatric Research Initiative) is amended—

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

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

''(d) NATIONAL PEDIATRIC RESEARCH NETWORK.—

''(1) NETWORK.—In carrying out the Initiative, the Director of NIH, in consultation with the Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development and in collaboration with other appropriate national research institutes and national centers that carry out activities involving pediatric research, may provide for the establishment of a National Pediatric Research Network consisting of the pediatric research consortia receiving awards under paragraph (2).

''(2) PEDIATRIC RESEARCH CONSORTIA.—

''(A) IN GENERAL.—The Director of NIH may award funding, including through grants, contracts, or other mechanisms, to public or private nonprofit entities—

''(i) for establishing or strengthening pediatric research consortia; and

''(ii) for providing support for such consortia, including with respect to—

''(I) basic, clinical, behavioral, or translational research to meet unmet pediatric research needs; and

''(II) training researchers in pediatric research techniques in order to address unmet pediatric research needs.

''(B) RESEARCH.—The Director of NIH may ensure that—

''(i) each consortium receiving an award under subparagraph (A) conducts or supports at least one category of research described in subparagraph (A)(ii)(I) and collectively such consortia conduct or support all such categories of research; and

''(ii) one or more such consortia provide training described in subparagraph (A)(ii)(II).

''(C) NUMBER OF CONSORTIA.—

''(i) IN GENERAL.—The Director of NIH may make awards under this paragraph for not more than 8 pediatric research consortia, with a minimum of one pediatric research consortium that prioritizes collaboration with institutions serving rural areas.

''(ii) EXCEPTION.—Notwithstanding clause (i), the Director of NIH may make awards under this paragraph for more than 8 pediatric research consortia based on a finding of need by the Director. Before making any award pursuant to the preceding sentence, the Director of NIH shall give written notice to the Congress of the Director's intent to make the award and shall include in the notice an explanation of the Director's finding of need.

''(D) ORGANIZATION OF CONSORTIUM.—Each consortium receiving an award under subparagraph (A) shall—

''(i) be formed from a collaboration of cooperating institutions;

''(ii) be coordinated by a lead institution;

''(iii) agree to disseminate scientific findings rapidly and efficiently; and

''(iv) meet such requirements as may be prescribed by the Director of NIH.

''(E) SUPPLEMENT, NOT SUPPLANT.—Any support received by a consortium under subparagraph (A) shall be used to supplement, and not supplant, other public or private support for activities authorized to be supported under this paragraph.

''(F) DURATION OF CONSORTIUM SUPPORT.—Support of a consortium under subparagraph (A) may be for a period of not to exceed 5 years. Such period may be extended at the discretion of the Director of NIH.

''(3) COORDINATION OF CONSORTIA ACTIVITIES.—The Director of NIH shall—

''(A) as appropriate, provide for the coordination of activities (including the exchange of information and regular communication) among the consortia established pursuant to paragraph (2); and

''(B) as appropriate, require the periodic preparation and submission to the Director of reports on the activities of each such consortium.

''(4) ASSISTANCE WITH REGISTRIES.—Each consortium receiving an award under paragraph (2)(A) shall provide assistance to the Centers for Disease Control and Prevention in the establishment or expansion of patient registries and other surveillance systems as appropriate and upon request by the Director of the Centers.

''(e) RESEARCH ON PEDIATRIC RARE DISEASES OR CONDITIONS.—In making awards under subsection (d)(2) for pediatric research consortia, the Director of NIH shall ensure that an appropriate number of such awards are awarded to such consortia that agree to—

''(1) focus primarily on pediatric rare diseases or conditions (including any such diseases or conditions that are genetic disorders or are related to birth defects); and

''(2) conduct or coordinate one or more multisite clinical trials of therapies for, or approaches to, the prevention, diagnosis, or treatment of one or more pediatric rare diseases or conditions.''.

TITLE III—CHILDREN'S HOSPITAL GME SUPPORT REAUTHORIZATION

SEC. 301. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) IN GENERAL.—Section 340E of the Public Health Service Act (42 U.S.C. 256e) is amended—

(1) in subsection (a), by striking ''through 2005 and each of fiscal years 2007 through 2011'' and inserting ''through 2005, each of fiscal years 2007 through 2011, and each of fiscal years 2013 through 2017'';

(2) in subsection (f)(1)(A)(iv), by inserting ''and each of fiscal years 2013 through 2017'' after ''2011''; and

(3) in subsection (f)(2)(D), by inserting ''and each of fiscal years 2013 through 2017'' after ''2011''.

(b) REPORT TO CONGRESS.—Section 340E(b)(3)(D) of the Public Health Service Act

(42 U.S.C. 256e(b)(3)(D)) is amended by striking ''Not later than the end of fiscal year 2011'' and inserting ''Not later than the end of fiscal year 2016''.

Amend the title so as to read: ''An Act to reduce preterm labor and delivery and the risk of pregnancy-related deaths and complications due to pregnancy; to reduce infant mortality caused by prematurity; to provide for a National Pediatric Research Network, including with respect to pediatric rare diseases or conditions; and to reauthorize support for graduate medical education programs in children's hospitals.''.

The SPEAKER pro tempore (Mr. WESTMORELAND). Pursuant to the rule, the gentleman from Pennsylvania (Mr. PITTS) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. PITTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials into the RECORD on S. 1440.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. PITTS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, S. 1440, the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Reauthorization, or the ''PREEMIE'' Reauthorization Act, would take important steps to protect and improve children's health. The bill includes three important programs: the PREEMIE Reauthorization Act, the National Pediatric Research Network, and the Children's Hospitals Graduate Medical Education Reauthorization.

The PREEMIE Reauthorization Act addresses one of the leading causes of neonatal death and a major cause of childhood disabilities: preterm birth. Since its passage in 2006, the PREEMIE Act has sponsored important research that has led to improved prevention and care of children born too early. Reauthorization will mean the continuation of the program that will lead to even better outcomes for children.

The National Pediatric Research Network is a proven way to support pediatric research by coordinating multicentered research activities, including those in rural areas. By working in teams, innovative research improves especially for diseases that are rare or affect a small population of children. Most of the approximately 7,000 rare diseases are pediatric and often genetic, and doctors do not have sufficient therapies to treat them. This bill will help alleviate that problem.

The Children's Hospital Graduate Medical Education Reauthorization would enable the Department of Health and Human Services to provide funding to freestanding children's hospitals to support the training of pediatricians and other residents. Prior to the enactment of CHGME, the number of residents in children's hospitals had declined by 13 percent. Now the program has enabled children's hospitals to increase their training programs by 35 percent.

In my home State of Pennsylvania, three premier children's hospitals, Children's Hospital of Pittsburgh, St. Christopher's Hospital for Children, and Children's Hospital of Philadelphia receive CHGME funds that support and ensure world-renowned health care for children.

CHGME is a significant achievement in pediatric health care in Pennsylvania and across the country. Despite these gains, shortages still exist, and the future of the pediatric workforce relies on the continuation of CHGME.

I commend the leadership on both sides of the aisle and in the committee for their leadership on this. These programs enjoy bipartisan support, and I urge my colleagues to support S. 1440.

I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield myself such time as I may consume.

I am pleased to rise in support of S. 1440, as amended. The legislation before us extends two existing programs and creates one new initiative, all activities that impact children's health.

The first title of the legislation reauthorizes the Prematurity Research Expansion and Education for Mothers who deliver Infants Early, or PREEMIE, Act through fiscal year 2017. The PREEMIE Act was signed into law in 2006, and I was proud to be a cosponsor of the original House legislation.

S. 1440, as amended, calls for further studies on factors related to prematurity, improved data on the national burden of preterm birth, continued preterm birth prevention efforts, and strengthened public and health provider education on risk factors for preterm delivery and treatments and outcomes for preterm infants. The legislation also codifies an advisory committee to the Secretary of Health and Human Services on infant mortality and directs the Secretary to coordinate existing quality studies on hospital readmissions and preterm infants.

Since the enactment of the PREEMIE Act, we've seen the preterm birth rate decline to its present level of just under 12 percent, the lowest rate we've seen since the late nineties. The good news is there's been progress in better understanding the causes of premature births and promoting interventions that work. On the other hand, however, we still don't know the causes of premature birth in up to 40 percent of cases. And then there's the cost to the health care system of premature births—more than $26 billion each year—not to mention the increased risks of serious disability and death for newborns and the tremendous toll prematurity takes on their families. And that's precisely why the goals of the PREEMIE Act remain just as salient as they were 6 years ago.

The second title is similar to the House-passed National Pediatric Research Network Act of 2012 and allows the National Institutes of Health to establish a national pediatric research network comprised of up to eight pediatric research consortia, or groups of collaborating institutions. The consortia will conduct basic clinical, behavioral, and translational research on pediatric diseases and conditions.

Among the eight consortia, the NIH Director will ensure that an appropriate number of awards go to consortia that focus primarily on pediatric rare diseases, such as spinal muscular atrophy or birth defects such as Down syndrome. There are many rare pediatric diseases, and in some of these diseases, the children are incredibly fragile. If we can allow for research to occur across the country, not just one single location, research can be done at a larger level because children could then participate without having to travel.

Additionally, we all know too well that, traditionally, pediatric research has been underfunded. That can make it hard to train and develop the research talent needed to address these devastating illnesses. The consortia can therefore be the training grounds for future researchers, helping to fill the pediatric pipeline.

Finally, the third title, Madam Speaker, of the amendment to S. 1440 reauthorizes the Children's Hospitals Graduate Medical Education, or CHGME, program through fiscal year 2017. The legislation maintains the current authorization level and will support the work of 56 children's hospitals training over 5,000 pediatric residents in 30 States.

The CHGME program was first established in 1999, following declines in pediatric training programs that threatened the stability of the pediatric workforce.

□ 1310

Like any parent knows, it's important to have a trusted health provider to turn to when your child is sick or hurt. In Congress, on a bipartisan basis, we recognize that if we didn't create and fund programs to train pediatricians, there wouldn't be anyone left to care for our kids.

Since its inception, the CHGME program has been a success story, supporting children's hospitals and their work to train future generations of our pediatric workforce, including pediatric subspecialists in very short supply. Representing only 1 percent of all hospitals, the small number of children's hospitals that participate in the program train approximately 40 percent of all pediatricians and nearly half of all pediatric specialists. That's why continuing this critical program will have a major impact on access to primary care and specialty care for kids.

Reauthorizing this program, Madam Speaker, was one of my top health priorities of the year, and I want to thank Chairman JOE PITTS, the chairman of

our Health Subcommittee, for working with me on this bill. Together with his help and leadership, we were able to move this bill through our committee and to the House floor last year. I'm hopeful that reauthorization of the CHGME program will finally make it to the President's desk as part of S. 1440.

I just want to take a moment to commend Chairman UPTON, Chairman PITTS, and Ranking Member WAXMAN for their leadership on this legislation. I have to recognize and thank the House sponsor of the PREEMIE Act and the National Pediatric Research Network Act, and those Energy and Commerce members: Congresswoman ESHOO, Congressman LANCE, Congresswoman CAPPS, and Congresswoman MCMORRIS RODGERS. They were really dedicated to these important issues.

Madam Speaker, I reserve the balance of my time.

Mr. PITTS. Madam Speaker, I yield 2 minutes to the gentleman from Georgia, one of the leaders on this issue, Dr. PHIL GINGREY.

Mr. GINGREY of Georgia. Madam Speaker, I thank the chairman for yielding.

The gentleman from New Jersey just gave attributions to so many members, both Republicans and Democrats, from the Energy and Commerce Committee that worked so long and hard on this legislation back originally in 2006 and now in the reauthorization of S. 1440, the PREEMIE Act.

There are a lot of statistics that some people may not be aware of. One is the fact that about two-thirds of all infant deaths in the first year of life are among the preterm infants. In 2008, 12.3 percent of all live births, over 500,000 babies, were born preterm.

Madam Speaker, let me put it a little bit in context. Prematurity or preterm birth is by definition a birth earlier than 37 weeks. Those children are usually not the problem. They're not the ones that end up with permanent disabilities. But there is a subset of prematurity, maybe sometimes referred to as ''immaturity,'' children that are born as early as 20 weeks, all the way up to 37 weeks. Those children are the ones that very often, if they survive, are left with permanent long-term disabilities. We see a lot of folks on the Hill coming down the halls of our office buildings, and sometimes they're in wheelchairs, sometimes they're visually impaired, sometimes they're hearing impaired, but so many of those adults and children that we see on Capitol Hill were born prematurely. So a piece of legislation like this is hugely important.

I'll end my remarks by just making it a little personal. My wife, Billie, and I, Madam Speaker, have 13 grandchildren, and the oldest will be 15 years old in about 3 weeks. And they were born at 26 weeks—they each weighed 1 pound and 12 ounces. Thank God they are virtually unimpaired today and in the eighth grade and doing well. It tugs at your heartstrings. This is something that is hugely important.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PITTS. I yield an additional 30 seconds to the gentleman from Georgia.

Mr. GINGREY of Georgia. The graduate medical education piece is very important because these children's hospitals, they see so many of these young kids. In fact, 50 percent or more of their patient population are Medicaid, and they need this funding for continuing medical education for pediatric residents.

I will just conclude with that and say how proud I am to be supportive of such a great piece of legislation.

Mr. PALLONE. Madam Speaker, I would like to now yield such time as she may consume to the sponsor of the House PREEMIE Act, the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the gentleman.

Madam Speaker, I'm very proud to rise in support of the PREEMIE Act legislation that I introduced with Congressman LEONARD LANCE. He's been a terrific partner not only on this legislation but on other pieces of legislation that we've moved through the Energy and Commerce Committee, and I salute him.

This bill will expand research, education, and prevention of preterm birth. As the mother of two children, I know how precious the earliest part of life is, and it's our responsibility to do everything we can to make sure that our little ones begin their lives with more than a fighting chance.

Each year, as was stated, half a million babies are born prematurely in our country, and preterm birth is the leading cause of newborn mortality and the second-leading cause of infant mortality. Babies born even a few weeks too early can require weeks to months of hospitalization after birth, and premature birth can sometimes lead to developmental delays and disability later in life.

In addition to the emotional and physical toll of prematurity, there are significant health care costs to families, to our medical systems, and our economy. A 2006 report by the Institute of Medicine found the cost associated with preterm birth in the United States was $26.2 billion annually, or $51,600 per infant born preterm. These are staggering amounts of dollars. While employers, private insurers, and individuals bear about half of the cost of health care for these infants, 40 percent is paid for by Medicaid. So it's in the best interest of healthy babies, hopeful families, and the budget of our country to decrease preterm births.

The good news is our investment in preventing prematurity is paying off. In 2006, I introduced and Congress passed the first ever comprehensive PREEMIE Act, and prematurity rates have declined since then. This is very good news. The better news is that today we're reauthorizing this law, which will build upon the momentum of the original law and provide us with new tools and knowledge to improve the lives and health of America's mothers and children.

The PREEMIE Act has been packaged with other important pediatric health bills. I thank the chairman of the subcommittee, Mr. PITTS, the chairman of our full committee, Mr. UPTON, the ranking member of the full committee, as well as Mr. PALLONE, and all of our colleagues.

You know very well, Madam Speaker, that we come to this place to do good things for our country that will strengthen our Nation. How proud I am that we are living up to that in presenting this bill here today.

In closing, I would also like to thank Erin Katzelnick-Wise of my staff, who has worked on this bill as if it were the most important thing she could do in her life, understanding that it is one of the most important things she could do in her life for children in our country; to the American Academy of Pediatricians, who have been so magnificent in instructing all of us in our work on this legislation; and a particular shoutout to Dr. Phil Pizzo, the dean of the Stanford School of Medicine, a pediatrician himself who at one time worked with great distinction at the National Institutes of Health.

□ 1320

Mr. PITTS. Madam Speaker, I yield 2½ minutes to the chairman of the full committee, the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. I, too, want to commend the Republicans and Democrats, who worked very, very hard to get this legislation to the floor and, hopefully, to the President's desk as soon as possible. I particularly commend Chairman PITTS and Ranking Member PALLONE, LEONARD LANCE, ANNA ESHOO, LOIS CAPPS, and the staffs, really, on both sides. I made a commitment to all of these Members early on that we would work very diligently to get this legislation here, and we are finally here.

Madam Speaker, this bill, S. 1440, known as the PREEMIE Reauthorization Act, is designed to strengthen health care for kids, particularly for vulnerable kids. Not only does the bill reauthorize the PREEMIE Act, but it also includes the reauthorization of the Children's Hospital Graduate Medical Education program, and it authorizes the National Pediatric Research Network.

The original PREEMIE Act that I sponsored brought attention to the problems related to preterm birth, and since its passage, the preterm birth rate has declined. Good news. Yet, despite that improvement, according to the CDC, still a half a million babies are born prematurely every year in this country. That's one out of eight. We can and we must do better. This reauthorization will continue to strengthen the ongoing effort to track,

prevent, and treat prematurity, ensuring that every child has a healthy start and a better chance at a healthy and a productive future.

Madam Speaker, the National Pediatric Research Network brings us a step closer in providing more help to children with unmet health needs, particularly to those with rare pediatric and genetic diseases. I've met a number of times with a family in my district, the Kennedys, whose wonderful little daughters—Brielle and Brooke, who are affectionately known in our office as ''Sleeping Beauty'' and ''Cinderella''—have a rare disease called spinal muscular atrophy. It's often difficult to conduct research into these diseases due to the very small number of kids with that disease, but today, we are working to provide families like the Kennedys and so many others with greater hope for a cure or an advancement in the treatment.

This bill will help establish pediatric research networks and the consortia that are effective in overcoming gaps in research. Networks and consortia will be comprised of leading institutions that will act as partners to consolidate and coordinate those research efforts.

The SPEAKER pro tempore (Mrs. EMERSON). The time of the gentleman has expired.

Mr. PITTS. I yield the gentleman an additional 30 seconds.

Mr. UPTON. With the passage of the Children's Hospital Graduate Medical Education in 1999, freestanding children's hospitals began receiving funds to support their pediatric medical residency programs. As a result, the number of pediatricians in the U.S. has grown steadily. Today, over 40 percent of the pediatricians and pediatric specialists are trained in the 57 freestanding children's hospitals that receive this funding. A proven track record. We need to get it done.

Again, I congratulate the Members on the floor today for getting this bill, hopefully, to the President's desk before the year is out.

Mr. PALLONE. I yield such time as she may consume to the Democratic sponsor of the House National Pediatric Research Network Act of 2012, which is the second title of the legislation before us, the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. I do want to acknowledge the gentlelady in the chair as my partner in the Capps-Emerson lectures and as my neighbor and a real friend.

Madam Speaker, I rise in strong support of the PREEMIE Reauthorization Act. This is an important bill to improve the health outcomes of pregnant women and their babies, and it shows our Nation's commitment to addressing the costly and emotionally troubling incidence of preterm birth. While this is enough reason for me to support this legislation, I would like to highlight two additional sections of the bill that will improve the health and well-being not only of newborns but of our children as they grow.

First, it includes the reauthorization of the Children's Hospital Graduate Medical Education program. This is a critical investment in both the health of our kids and in the health of our economy by bringing new, talented individuals into the health care workforce.

From my years as a school nurse, I know the difficulty that children experience, especially those with special health care needs, when they look for a pediatric specialist. Over the years, we have seen how CHGME programs have made a measurable impact in alleviating that burden, allowing these children and their families to focus on healing. I am proud to be an original cosponsor of this legislation and will continue to champion it in the House.

While we must ensure that the providers are available for our kids, we are still far behind on too many important diagnostics, cures, and treatments for many of our ailing children. That is why this bill also includes the National Pediatric Research Network Act, which is a bill that I coauthored with my colleague, Representative CATHY MCMORRIS RODGERS.

This legislation will help strengthen and coordinate our Nation's research on pediatric diseases. It will disseminate research findings quickly so that all children may benefit, especially those who have rare diseases; and it will expand the geographic scope of research, giving sick kids easier access to research programs and to clinical trials. Moreover, this bill places an added emphasis on researching children's rare diseases, like spinal muscular atrophy, as my colleague Mr. UPTON has noted, and on developing new treatments to fight them.

The low prevalence of these diseases makes them particularly hard to research, and yet these diseases have such a marked impact on the lives of far too many families and communities, like the Strong family of Santa Barbara. My constituents Bill and Victoria Strong have worked tirelessly on behalf of their daughter, Gwendolyn, and all children with spinal muscular atrophy and other rare diseases. The work they've done to help raise the profile of pediatric rare disease research is going to help families all across the Nation. I thank them.

I also thank the leadership of the Energy and Commerce Committee—Chairman UPTON, Ranking Member WAXMAN, Chairman PITTS, and Ranking Member PALLONE—for their dedication to this bill. I thank the staff, especially Ruth Katz, for working across the aisle and across the Capitol to bring a strong bill now to the floor.

I urge my colleagues to support this bipartisan bill. I urge its swift passage in the Senate so that we can improve the health and well-being of all infants and all children.

Mr. PITTS. Madam Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. LANCE), a leader on this issue.

Mr. LANCE. It is wonderful to see you in the chair, and I congratulate you on your magnificent service to the people of Missouri and the Nation.

I rise in strong support of S. 1440, to reauthorize the 2006 PREEMIE Act and to provide important continued research, education, and intervention in the national effort to reduce preterm births.

Madam Speaker, our Nation's premature birth rate is one of the highest in the world, and it is the leading cause of newborn death in the United States. Infants born just a few weeks too soon can face serious health challenges and are at risk for lifelong health and learning disabilities. In addition to its human toll, premature birth costs our economy billions of dollars per year; and while the medical community has made great strides in identifying the risk factors associated with premature births, far too many premature births today have no known causes.

That is why the Members of the House and Senate have worked in a bipartisan and bicameral fashion to reauthorize the 2006 PREEMIE Act so that we may continue to spur innovative solutions that will ultimately lead not just to healthier babies but to lower annual health care costs.

I thank Chairman UPTON and Chairman PITTS and Ranking Member WAXMAN and Ranking Member PALLONE for their steadfast leadership on this issue as well as to thank Senators LAMAR ALEXANDER and MICHAEL BENNET. Once again, I commend Congresswoman ANNA ESHOO of California for working on an important issue to the health and well-being of the American people.

While many complain about the partisan nature of Congress, we have worked in a cooperative fashion on this and other issues, as has the entire Energy and Commerce Committee. It is in that bipartisan spirit that I ask all of my colleagues to join with us in the support of the PREEMIE Reauthorization Act so that we as a Nation will be able to continue our focus on premature birth research and prevention.

Mr. PALLONE. I have no additional speakers, Madam Speaker, so I would simply ask that we support this legislation and pass it on a bipartisan basis.

I yield back the balance of my time.

□ 1330

Mr. PITTS. Madam Speaker, I have no further speakers. I urge support for this bipartisan legislation.

I yield back the balance of my time.

Mr. WAXMAN. Madam Speaker, I rise in support of S. 1440, as amended, and urge my colleagues to support the bill as well.

As amended, S. 1440 is comprised of the authorization or re-authorization of three different programs, all related to children's health. Together, these provisions constitute a bipartisan effort to help ensure that our kids—and their health care needs—are appropriately and adequately addressed.

Title One of the bill would reauthorize and improve the Prematurity Research Expansion and Education for Mothers Who Deliver Infants Early—or PREEMIE—Act. Established in

2006, the PREEMIE Act expands federal research related to preterm labor and delivery, and the care and treatment, and outcomes of preterm and low birth weight infants. It also supports education programs for health professionals and the public on prematurity. Title One is designed to enhance these activities and represents a renewed commitment to our nation's efforts to reduce premature birth, the leading killer of newborns.

Title Two of S. 1440 would allow the National Institutes of Health to establish a national pediatric research network dedicated to finding treatments and cures for pediatric diseases and conditions—especially those that are rare. In addition to the research itself, Title Two places special emphasis on professional training for future pediatric researchers. These and other related components of Title Two are intended to build on the strong body of pediatric research that NIH already conducts and supports. I would encourage NIH to take full advantage of this opportunity.

Finally, Title Three of the bill would reauthorize the children's hospital graduate medical education—or CHGME—program. This program provides ongoing and consistent financial support to hospitals such as Children's Hospital of Los Angeles for the training of doctors who want to specialize in pediatrics. Over the years, the CHGME program has been enormously successful in reversing the significant decline in the number of pediatrician trainees across the country. Indeed, today, children's hospitals nationwide that are supported by the program train 40% of all pediatricians and 43% of all pediatric specialists.

As I have noted, this package of programs is a bi-partisan initiative that reflects the work of several members of the Energy and Commerce Committee. I especially want to note Congresswoman ESHOO, the Democratic sponsor of the original PREEMIE Reauthorization Act; Congresswoman CAPPS, the Democratic sponsor of the original National Pediatric Research Network Act; and Congressman PALLONE, the Democratic sponsor of the original Children's Hospital GME Support Reauthorization Act. All of them and all of us—on both sides of the aisle—have much to be proud of in supporting S. 1440, as amended.

I urge my colleagues to vote for S. 1440, as amended.

Mrs. MCMORRIS RODGERS. Madam Speaker, as a mother, I am reminded on a daily basis of the importance of the health of our Nation's children.

For that reason, I am proud to support the Prematurity Research Expansion and Education for Mothers who deliver Infants Early (PREEMIE) Act. This important legislation authorizes research to prevent preterm births and it requires the Secretary of HHS to coordinate our Nation's efforts to achieve this goal.

This legislation also amends the Public Health Service Act to extend and reauthorize appropriations for Children's Hospital Graduate Medical Education. This is the source of training of most of our Nation's pediatricians.

The PREEMIE act also includes legislation introduced by Representative CAPPS and myself, the National Pediatric Research Network Act which will build upon our Nation's commitment to pediatric medical research. That commitment has led to the prevention and treatment of terrible conditions such as polio, meningitis, childhood leukemia, and congenital heart disease.

Research networks have a proven track record in their ability to ensure collaboration and sharing of resources which, in turn, have led to medical discoveries that have improved lives. This legislation will authorize NIH to establish up to 8 pediatric research networks throughout the nation. Each network will be selected by NIH through a competitive review process. These networks will allow multiple institutions to work together in a "hub and spoke" fashion in order to encourage collaboration and resource sharing.

These pediatric networks will improve health outcomes for children who have conditions such as spinal muscular atrophy, Down syndrome, and Fragile X. This will be accomplished by encouraging teamwork among researchers, patients, and NIH.

Today, I am proud to vote for measures to improve the health of our Nation's children.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. PITTS) that the House suspend the rules and pass the bill, S. 1440, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MEDICARE IVIG ACCESS AND STRENGTHENING MEDICARE AND REPAYING TAXPAYERS ACT OF 2012

Mr. BRADY of Texas. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 1845) to provide for a study on issues relating to access to intravenous immune globulin (IVIG) for Medicare beneficiaries in all care settings and a demonstration project to examine the benefits of providing coverage and payment for items and services necessary to administer IVIG in the home, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1845

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012''.

TITLE I—MEDICARE IVIG ACCESS

SEC. 101. MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under part B of title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globin for the treatment of primary immune deficiency diseases.

(b) DURATION AND SCOPE.—

(1) DURATION.—Beginning not later than one year after the date of enactment of this Act, the Secretary shall conduct the demonstration project for a period of 3 years.

(2) SCOPE.—The Secretary shall enroll not more than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency disease for participation in the demonstration project. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time.

(c) COVERAGE.—Except as otherwise provided in this section, items and services for which payment may be made under the demonstration program shall be treated and covered under part B of title XVIII of the Social Security Act in the same manner as similar items and services covered under such part.

(d) PAYMENT.—The Secretary shall establish a per visit payment amount for items and services needed for the in-home administration of intravenous immune globin based on the national per visit low-utilization payment amount under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary to carry out the demonstration project.

(f) STUDY AND REPORT TO CONGRESS.—

(1) INTERIM EVALUATION AND REPORT.—Not later than three years after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains an interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

(2) FINAL EVALUATION AND REPORT.—Not later than one year after the date of completion of the demonstration project, the Secretary shall submit to Congress a report that contains the following:

(A) A final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k et seq.).

(C) An update to the report entitled ''Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)'', issued in February 2007 by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(g) FUNDING.—There shall be made available to the Secretary to carry out the demonstration project not more than $45,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(h) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term ''demonstration project'' means the demonstration project conducted under this section.

(2) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is enrolled for benefits under part B of title XVIII of the Social Security Act.

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

TITLE II—STRENGTHENING MEDICARE SECONDARY PAYER RULES

SEC. 201. DETERMINATION OF REIMBURSEMENT AMOUNT THROUGH CMS WEBSITE TO IMPROVE PROGRAM EFFICIENCY.

Section 1862(b)(2)(B) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(vii) USE OF WEBSITE TO DETERMINE FINAL CONDITIONAL REIMBURSEMENT AMOUNT.—

''(I) NOTICE TO SECRETARY OF EXPECTED DATE OF A SETTLEMENT, JUDGMENT, ETC.—In