The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 776.

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

There was no objection.

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

Mr. Speaker, for 35 years, the Emergency Medical Services for Children, or EMSC, program has been the only Federal grant program specifically focused on addressing the needs of children in emergency medical systems.

If ever a parent or caregiver is required to call 911 to get emergency care for a child, they should know that the child will receive the medical care that they need.

The EMSC program helps provide this peace of mind by enhancing care for all children, no matter where they live, travel, or go to school.

The EMSC program invests in research, care delivery enhancements, data monitoring, innovation in both prehospital EMS settings as well as hospital emergency departments.

The program has led to real results and better care for children. For example, research funded by EMSC has led to a new pediatric head injury algorithm, which has led to a reduction in unnecessary radiation exposure from CT scans in children who have suffered head injuries.

Mental health and substance abuse screenings have been created to better assess children in emergency situations, and a full 50 percent of hospitals have adopted new guidelines to assist them in transferring children to appropriate facilities when specialized care is needed.

Any doctor, nurse, or EMS provider will tell you that we can't simply treat children as small adults. They need specialized treatment and protocols to ensure that the care they receive is appropriate and available to them when and where they need it. Passing this 5-year reauthorization of the EMSC program will continue to provide innovative and appropriate care to children.

Mr. Speaker, I hope all of my colleagues will join me in supporting this bill today, and I reserve the balance of my time.

Mr. CARTER of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today to speak in support of H.R. 776, the Emergency Medical Services for Children Program Reauthorization Act of 2019.

I would like to thank Representatives PETER KING and KATHY CASTOR for their work on this important legislation.

The Emergency Medical Services for Children program was enacted in 1984 to provide grant funding to increase the ability of emergency medical systems to care for pediatric populations. Not only does this program provide funding so that emergency departments and hospitals can equip themselves with the appropriate pediatric medical tools, it enables partnerships and drives research and innovation in emergency care for children.

Whether children require emergency care following a car crash or fall ill in the middle of the night with nowhere else to turn, our emergency medical system needs to have staff trained in how to treat children. A major part of that is providing the resources to equip healthcare professionals with the right size medical tools.

The Emergency Medical Services for Children program provides grants for the State Partnership Program to integrate pediatric care into the EMS system and reduce pediatric morbidity and mortality. States can focus on providing quality prehospital and hospital-based care, in addition to establishing plans to handle disaster and trauma care.

Our Nation's healthcare workforce still has much to learn about the treatment of pediatric populations, which is why continued research through the Pediatric Emergency Care Applied Research Network is crucial. This body is the first federally funded pediatric emergency medicine research network in the country and conducts a wide variety of research about acute illness and injuries in children.

The reauthorization of the Emergency Medical Services for Children program is critical to maintaining and improving pediatric emergency care. Mr. Speaker, I urge strong support of H.R. 776, and I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I would urge support for this bipartisan legislation, and I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, I rise today in support of H.R. 776, the Emergency Medical Services for Children Program Reauthorization Act, sponsored by Representatives Peter King and Kathy Castor. This legislation reauthorizes grants that focus on addressing the unique needs of children in emergency medical systems, with the ultimate goal of reducing the prevalence of morbidity and mortality in children that may occur as a result of acute illness and severe injury. This is really critical legislation for parents and children in our communities—no one should have to know the pain of losing a child. I urge my fellow House members to support this bill.

Ms. JACKSON LEE. Mr. Speaker, as a senior member of the Committee on the Budget, I rise in strong support of H.R. 776, the Emergency Medical Services for Children Program Reauthorization Act of 2019.

The Emergency Medical Services for Children Program (EMSC) reduces child and youth mortality and morbidity due to severe illness or injury by increasing awareness among health professionals, providers and planners, and the general public of the special needs of children receiving emergency medical care.

Specifically, the EMSC program has provided grants to all states since I 1985 for the State Partnership, Targeted Issues, State Partnership Regionalization of Care, and The Pediatric Emergency Care Applied Research Network.

Additionally, the EMSC program has been used to establish national resource centers and a pediatric emergency care research network.

Mr. Speaker, the majority of children are treated in community and rural emergency departments rather than specialized centers such as large children's hospitals.

As a result, pediatric visits make up less than 20 percent of cases at emergency departments, so they lack the quality of pediatric emergency care needed for established practice guidelines.

I support H.R. 776 because Congress has a responsibility to ensure that every child has access to necessary emergency medical services and that no child in our nation is left untreated.

Mr. Speaker, I urge my colleagues to join me in supporting H.R. 776, the "Emergency Medical Services for Children Program Reauthorization Act of 2019."

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 776.

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

A motion to reconsider was laid on the table.

NEWBORN SCREENING SAVES LIVES REAUTHORIZATION ACT OF 2019

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2507) to amend the Public Health Service Act to reauthorize certain programs under part A of title XI of such Act relating to genetic diseases, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2507

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 "Newborn Screening Saves Lives Reauthorization Act of 2019".

SEC. 2. IMPROVED NEWBORN AND CHILD SCREENING AND FOLLOW-UP FOR HERITABLE DISORDERS.

(a) PURPOSES.—Section 1109(a) of the Public Health Service Act (42 U.S.C. 300b–8(a)) is amended—

(1) in paragraph (1), by striking "enhance, improve or" and inserting "facilitate, enhance, improve, or";

(2) by amending paragraph (3) to read as follows:

"(3) to develop, and deliver to parents, families, and patient advocacy and support groups, educational programs that—

"(A) address newborn screening counseling, testing (including newborn screening pilot studies), follow-up, treatment, specialty services, and long-term care;

"(B) assess the target audience's current knowledge, incorporate health communications strategies, and measure impact; and

“(C) are at appropriate literacy levels;”; and

(3) in paragraph (4)—

(A) by striking “followup” and inserting “follow-up”; and

(B) by inserting before the semicolon at the end the following: “, including re-engaging patients who have not received recommended follow-up services and supports”.

(b) Approval Factors.—Section 1109(c) of the Public Health Service Act (42 U.S.C. 300b–8(c)) is amended—

(1) by striking “or will use” and inserting “will use”; and

(2) by inserting “, or will use amounts received under such grant to enhance capacity and infrastructure to facilitate the adoption of,” before “the guidelines and recommendations”.

SEC. 3. ADVISORY COMMITTEE ON HERITABLE DISORDERS IN NEWBORNS AND CHILDREN.

Section 1111 of the Public Health Service Act (42 U.S.C. 300b–10) is amended—

(1) in subsection (b)—

(A) in paragraph (5), by inserting “and adopt process improvements” after “take appropriate steps”;

(B) in paragraph (7) by striking “and” at the end;

(C) by redesignating paragraph (8) as paragraph (9);

(D) by inserting after paragraph (7) the following:

“(8) develop, maintain, and publish on a publicly accessible website consumer-friendly materials detailing—

“(A) the uniform screening panel nomination process, including data requirements, standards, and the use of international data in nomination submissions; and

“(B) the process for obtaining technical assistance for submitting nominations to the uniform screening panel and detailing the instances in which the provision of technical assistance would introduce a conflict of interest for members of the Advisory Committee; and”;

(E) in paragraph (9), as redesignated—

(i) by redesignating subparagraphs (K) and (L) as subparagraphs (L) and (M), respectively; and

(ii) by inserting after subparagraph (J) the following:

“(K) the appropriate and recommended use of safe and effective genetic testing by health care professionals in newborns and children with an initial diagnosis of a disease or condition characterized by a variety of genetic causes and manifestations;”; and

(2) in subsection (g)—

(A) in paragraph (1) by striking “2019” and inserting “2024”; and

(B) in paragraph (2) by striking “2019” and inserting “2024”.

SEC. 4. CLEARINGHOUSE OF NEWBORN SCREENING INFORMATION.

Section 1112(c) of the Public Health Service Act (42 U.S.C. 300b–11(c)) is amended by striking “and supplement, not supplant, existing information sharing efforts” and inserting “and complement other Federal newborn screening information sharing activities”.

SEC. 5. LABORATORY QUALITY AND SURVEILLANCE.

Section 1113 of the Public Health Service Act (42 U.S.C. 300b–12) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking “performance evaluation services,” and inserting “development of new screening tests,”; and

(ii) by striking “and” at the end;

(B) in paragraph (2)—

(i) by striking “performance test materials” and inserting “test performance materials”; and

(ii) by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(3) performance evaluation services to enhance disease detection, including the development of tools, resources, and infrastructure to improve data analysis, test result interpretation, data harmonization, and dissemination of laboratory best practices.”; and

(2) in subsection (b) to read as follows:

“(b) Surveillance Activities.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and taking into consideration the expertise of the Advisory Committee on Heritable Disorders in Newborns and Children established under section 1111, shall provide for the coordination of national surveillance activities, including—

“(1) standardizing data collection and reporting through the use of electronic and other forms of health records to achieve real-time data for tracking and monitoring the newborn screening system, from the initial positive screen through diagnosis and long-term care management; and

“(2) by promoting data sharing linkages between State newborn screening programs and State-based birth defects and developmental disabilities surveillance programs to help families connect with services to assist in evaluating long-term outcomes.”.

SEC. 6. HUNTER KELLY RESEARCH PROGRAM.

Section 1116 of the Public Health Service Act (42 U.S.C. 300b–15) is amended—

(1) in subsection (a)(1)—

(A) by striking “may” and inserting “shall”; and

(B) in subparagraph (D)—

(i) by inserting “, or with a high probability of being recommended by,” after “recommended by”; and

(ii) by striking “that screenings are ready for nationwide implementation” and inserting “that reliable newborn screening technologies are piloted and ready for use”; and

(2) in subsection (b) to read as follows:

“(b) Funding.—In carrying out the research program under this section, the Secretary and the Director shall ensure that entities receiving funding through the program will provide assurances, as practicable, that such entities will work in consultation with State departments of health, as appropriate.”.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS FOR NEWBORN SCREENING PROGRAMS AND ACTIVITIES.

Section 1117 of the Public Health Service Act (42 U.S.C. 300b–16) is amended—

(1) in paragraph (1)—

(A) by striking “$11,900,000” and inserting “$31,000,000”;

(B) by striking “2015” and inserting “2020”; and

(C) by striking “2019” and inserting “2024”; and

(2) in paragraph (2)—

(A) by striking “$8,000,000” and inserting “$29,650,000”;

(B) by striking “2015” and inserting “2020”; and

(C) by striking “2019” and inserting “2024”.

SEC. 8. INSTITUTIONAL REVIEW BOARDS; ETHICS GUIDANCE PROGRAM.

Section 12 of the Newborn Screening Saves Lives Reauthorization Act of 2014 (42 U.S.C. 289 note) is amended to read as follows:

“SEC. 12. INSTITUTIONAL REVIEW BOARDS; ETHICS GUIDANCE PROGRAM.

“Research on nonidentified newborn dried blood spots shall be considered secondary research (as that term is defined in section 46.104(d)(4) of title 45, Code of Federal Regulations (or successor regulations)) with nonidentified biospecimens for purposes of federally funded research conducted pursuant to the Public Health Service Act (42 U.S.C. 200 et seq.).”.

SEC. 9. NAM REPORT ON THE MODERNIZATION OF NEWBORN SCREENING.

(a) Study.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall seek to enter into an agreement with the National Academy of Medicine (in this section referred to as “NAM”) (or if NAM declines to enter into such an agreement, another appropriate entity) under which NAM, or such other appropriate entity, agrees to conduct a study on the following:

(1) The uniform screening panel review and recommendation processes to identify factors that impact decisions to add new conditions to the uniform screening panel, to describe challenges posed by newly nominated conditions, including low-incidence diseases, late onset variants, and new treatments without long-term efficacy data.

(2) The barriers that preclude States from adding new uniform screening panel conditions to their State screening panels with recommendations on resources needed to help States implement uniform screening panel recommendations.

(3) The current state of federally and privately funded newborn screening research with recommendations for optimizing the capacity of this research, including piloting multiple prospective conditions at once and addressing rare disease questions.

(4) New and emerging technologies that would permit screening for new categories of disorders, or would make current screening more effective, more efficient, or less expensive.

(5) Technological and other infrastructure needs to improve timeliness of diagnosis and short- and long-term follow-up for infants identified through newborn screening and improve public health surveillance.

(6) Current and future communication and educational needs for priority stakeholders and the public to promote understanding and knowledge of a modernized newborn screening system with an emphasis on evolving communication channels and messaging.

(7) The extent to which newborn screening yields better data on the disease prevalence for screened conditions and improves long-term outcomes for those identified through newborn screening, including existing systems supporting such data collection and recommendations for systems that would allow for improved data collection.

(8) The impact on newborn morbidity and mortality in States that adopt newborn screening tests included on the uniform panel.

(b) Public Stakeholder Meeting.—In the course of completing the study described in subsection (a), NAM or such other appropriate entity shall hold not less than one public meeting to obtain stakeholder input on the topics of such study.

(c) Report.—Not later than 18 months after the effective date of the agreement under subsection (a), such agreement shall require NAM, or such other appropriate entity, to submit to the Secretary of Health and Human Services and the appropriate committees of jurisdiction of Congress a report containing—

(1) the results of the study conducted under subsection (a);

(2) recommendations to modernize the processes described in subsection (a)(1); and

(3) recommendations for such legislative and administrative action as NAM, or such other appropriate entity, determines appropriate.

(d) Authorization of Appropriations.—There is authorized to be appropriated

$2,000,000 for the period of fiscal years 2020 and 2021 to carry out this section.

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

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 2507.

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

There was no objection.

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

Mr. Speaker, every year over 12,000 newborns are born with conditions that require early detection and treatment. With proper screening, parents can receive education and children can receive appropriate follow-up and treatment and, ultimately, better long-term health outcomes.

Over the years, as more screening tests and treatments have become available as we have expanded our medical and scientific knowledge, we have also seen greater potential for improving outcomes for children.

However, prior to Congress passing the first Newborn Screening Saves Lives Act in 2008, a patchwork of State requirements for screening led to some newborns screened for many disorders and others for very few.

Since the Newborn Screening law was enacted, we have seen tremendous progress around the country, with all 50 States screening for at least 29 recommended conditions. But as we develop new screening tests and treatments for diseases once thought untreatable, we must ensure that States are able to adopt recommended screening tests more quickly.

The bill we are considering today will do that by reauthorizing the program for 5 years, with higher authorization levels, improved processes and pilot testing for new screening tests, and a study focused on how we can better modernize newborn screening for the future.

This bipartisan bill will bring us closer to the goal of every child born in the United States receiving all recommended screening tests and will improve countless lives of the youngest Americans.

Mr. Speaker, I am proud to support it and ask all of my colleagues to join me in passing it today, and I reserve the balance of my time.

Mr. CARTER of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise to speak in support of H.R. 2507, the Newborn Screening Saves Lives Reauthorization Act of 2019.

Newborn screening is critical in early detection and intervention for conditions, some life-threatening, for our Nation's infants. These screenings inform both physicians and the families of a newborn what steps may be necessary to treat or prevent further health complications as the infant ages.

The Newborn Screening Saves Lives Act, which passed for the first time in 2008, aims to improve the ability to address pediatric health by standardizing newborn screening programs.

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Newborn screenings are incredibly important in providing physicians and families with information regarding their baby's health, enabling them to practice early intervention and treatment, if necessary.

According to the March of Dimes, in 2017, only 10 States and Washington, D.C., required infant screening for the recommended disorders.

Since enactment of the Newborn Screening Saves Lives Act, all the States, D.C., and Puerto Rico screen for at least 29 of the 35 recommended conditions.

This bill would reauthorize funding for the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the National Institutes of Health to ensure that our newborn screening remains comprehensive and that our Nation's healthcare providers are adequately equipped to conduct the screenings.

Newborn screenings are for serious but rare conditions that families and doctors may otherwise be unable to detect at birth.

Newborns are screened in the hospital when they are 1 or 2 days old by blood tests, in addition to hearing and heart screenings. About 1 in 300 newborns has a condition that can be detected via newborn screening.

By catching these disorders early, many can be managed successfully, allowing children to live fuller, better lives. However, if not detected and left untreated, these conditions can impact a child for the rest of their life by causing disabilities, delays in development, illness, or even death.

Prior to the passage of the initial bill in 2008, States had varying standards for newborn screening. Some States were only screening for 4 conditions in 2002, when other States were screening for more than 30.

Reauthorizing the Newborn Screening Saves Lives Act will allow the CDC to work with States to continue to level the playing field and provide for equal access to newborn screenings across the country.

H.R. 2507 also reauthorizes grants through the Health Resources and Services Administration that not only allows for expansion of screening programs but improved follow-up care after a detection.

The bill also allows for the continuation of the National Institutes of Health Hunter Kelly Newborn Screening program, which helps to identify new treatments for conditions detected in newborn screenings.

I applaud Representatives ROYBAL-ALLARD and SIMPSON for their work on this bill, and I urge my fellow Members to support H.R. 2507.

Mr. Speaker, I have no further speakers at this time. I urge passage of this bill, and I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. ROYBAL-ALLARD), the chairwoman of the Homeland Security Appropriations Subcommittee.

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise to support reauthorization of my Newborn Screening Saves Lives Act, which I first introduced in 2002.

Let me begin by extending my sincere gratitude to Congressman MIKE SIMPSON for our 15-year partnership championing newborn screening. Many thanks to Congresswomen KATHERINE CLARK and JAIME HERRERA BEUTLER who, this year, joined us as House champions. And my heartfelt appreciation to the coalition of public health groups, who continue to support my newborn screening efforts, especially the March of Dimes and the APHL.

Newborn screening involves a baby receiving a simple blood test to identify life-threatening diseases before symptoms begin. Prior to the first newborn screening test being developed, these children would have died or suffered lifelong disabilities.

And, until enactment of my original newborn screening bill in 2008, newborn screenings and access to follow-up information were not consistent and available to families in all communities. At that time, only 10 States and the District of Columbia required infants to be screened for a complete panel of recommended disorders, and there was no Federal repository of information on the diseases.

Today, 49 States and D.C. require screening of at least 31 of the 35 core treatable conditions, and a national clearinghouse of newborn screening information is available for parents and professionals.

Rapid identification and treatment make the difference between health and disability—or even life and death—for the approximately 12,000 babies who, each year, test positive for one of these serious conditions.

In addition, this simple test saves our healthcare system millions of dollars in care for each child who is identified and treated early.

This truly public health success story exemplifies what can be accomplished when private and public institutions, industry, advocates, scientists, providers, and parents partner to ensure a healthier future for our children.

Mr. Speaker, to maintain and advance the incredible progress that we have made over the last decade, we must reauthorize the Newborn Screening Saves Lives Act.

Passing H.R. 2507 will ensure the advisory committee continues its critical work of recommending new screenings to State programs. It will guarantee access to the most current follow-up programs and educational materials for parents and providers, as well as high-quality technical assistance for State programs and public health labs.

Reauthorization will also commission a National Academies of Sciences study to make recommendations for a 21st century newborn screening system.

Mr. Speaker, I urge a ''yes'' vote on the passage of H.R. 2507 to ensure all our newborns receive the comprehensive and consistent testing and follow up that they will need for a healthy and productive life.

Mr. PALLONE. Mr. Speaker, I have no additional speakers. I would ask my colleagues, on a bipartisan basis, to support this legislation. I thank the sponsor, the chairwoman, and I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, as a senior member of both the Judiciary Committee and the Committee on Homeland Security, I rise in strong support of H.R. 2507, the "Newborn Screening Saves Lives Reauthorization Act of 2019."

The Newborn Screening Saves Lives Reauthorization Act would yield major improvements in both the screening and follow up processes involved in the testing of infants for heritable diseases and conditions.

In the United States, more than 4,000,000 infants and children are screened every year, and up to 4,000 of the children test positive for one or more disease or disorder.

Mr. Speaker, 4,000 conditions detected are 4,000 young lives saved, as many of the diseases on the uniform screening panel, the list of conditions that newborns are tested for, are very treatable but can be deadly if left unaddressed.

However, there is an ever-present need to continue adapting the panel of conditions that newborns and young children are tested for, as improvements in technology allow medical professionals to identify new diseases, sooner.

Mr. Speaker, children and their families should have access to state of the art testing, and treatments.

H.R. 2507 specifically improves the current Newborn Screening Act in several ways, including:

Creating new educational strategies and practices regarding the screening and follow-up treatments for heritable diseases and conditions;

Creating an advisory committee for heritable diseases in newborns and children;

Creating a Clearinghouse of newborn screening information;

Improving laboratory quality and surveillance, which includes implementing new tools, resources and infrastructure, to improve data analysis, interpretation and lab practices;

Increasing funding for the Hunter Kelly Institute; and

Authorizing $2 million in Appropriations to the National Academy of Medicine, to fund studies dedicated to further improving the practice and procedure of the Uniform Screening Panel.

The screening of children has already been proven to be effective, and improvements and additions to the panel of diseases that are tested for can only result in more lives being saved.

I urge all members to join me in voting to pass H.R. 2507, the "Newborn Screening Saves Lives Reauthorization Act of 2019."

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 2507, 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.

CONSENSUS CALENDAR

The SPEAKER pro tempore. The Chair announces the Speaker's designation, pursuant to clause 7(a)(1) of rule XV, of H.R. 693 as the measure on the Consensus Calendar to be considered this week.

U.S. SENATOR JOSEPH D. TYDINGS MEMORIAL PREVENT ALL SORING TACTICS ACT OF 2019

Mr. SCHRADER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 693) to amend the Horse Protection Act to designate additional unlawful acts under the Act, strengthen penalties for violations of the Act, improve Department of Agriculture enforcement of the Act, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 693

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 ''U.S. Senator Joseph D. Tydings Memorial Prevent All Soring Tactics Act of 2019'' or the ''PAST Act''.

SEC. 2. INCREASED ENFORCEMENT UNDER HORSE PROTECTION ACT.

(a) DEFINITIONS.—Section 2 of the Horse Protection Act (15 U.S.C. 1821) is amended—

(1) by redesignating paragraphs (1), (2), (3), and (4) as paragraphs (2), (3), (4), and (5), respectively;

(2) by inserting before paragraph (2) (as so redesignated) the following new paragraph:

''(1)(A) The term 'action device' means any boot, collar, chain, roller, or other device that encircles or is placed upon the lower extremity of the leg of a horse in such a manner that it can—

''(i) rotate around the leg or slide up and down the leg, so as to cause friction; or

''(ii) strike the hoof, coronet band, fetlock joint, or pastern of the horse.

''(B) Such term does not include soft rubber or soft leather bell boots or quarter boots that are used as protective devices.''; and

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

''(6)(A) The term 'participate' means engaging in any activity with respect to a horse show, horse exhibition, or horse sale or auction, including—

''(i) transporting or arranging for the transportation of a horse to or from a horse show, horse exhibition, or horse sale or auction;

''(ii) personally giving instructions to an exhibitor; or

''(iii) being knowingly present in a warm-up area, inspection area, or other area at a horse show, horse exhibition, or horse sale or auction that spectators are not permitted to enter.

''(B) Such term does not include spectating.''.

(b) FINDINGS.—Section 3 of the Horse Protection Act (15 U.S.C. 1822) is amended—

(1) in paragraph (3)—

(A) by inserting ''and soring horses for such purposes'' after ''horses in intrastate commerce''; and

(B) by inserting ''in many ways, including by creating unfair competition, by deceiving the spectating public and horse buyers, and by negatively impacting horse sales'' before the semicolon;

(2) in paragraph (4), by striking ''and'' at the end;

(3) in paragraph (5), by striking the period at the end and inserting a semicolon; and

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

''(6) the Inspector General of the Department of Agriculture has determined that the program through which the Secretary inspects horses is inadequate for preventing soring;

''(7) historically, Tennessee Walking Horses, Racking Horses, and Spotted Saddle Horses have been subjected to soring; and

''(8) despite regulations in effect related to inspection for purposes of ensuring that horses are not sore, violations of this Act continue to be prevalent in the Tennessee Walking Horse, Racking Horse, and Spotted Saddle Horse breeds.''.

(c) HORSE SHOWS AND EXHIBITIONS.—Section 4 of the Horse Protection Act (15 U.S.C. 1823) is amended—

(1) in subsection (a)—

(A) by striking ''appointed'' and inserting ''licensed''; and

(B) by adding at the end the following new sentences: ''In the first instance in which the Secretary determines that a horse is sore, the Secretary shall disqualify the horse from being shown or exhibited for a period of not less than 180 days. In the second instance in which the Secretary determines that such horse is sore, the Secretary shall disqualify the horse for a period of not less than one year. In the third instance in which the Secretary determines that such horse is sore, the Secretary shall disqualify the horse for a period of not less than three years.'';

(2) in subsection (b) by striking ''appointed'' and inserting ''licensed'';

(3) by striking subsection (c) and inserting the following new subsection:

''(c)(1)(A) The Secretary shall prescribe by regulation requirements for the Department of Agriculture to license, train, assign, and oversee persons qualified to detect and diagnose a horse which is sore or to otherwise inspect horses at horse shows, horse exhibitions, or horse sales or auctions, for hire by the management of such events, for the purposes of enforcing this Act.

''(B) No person shall be issued a license under this subsection unless such person is free from conflicts of interest, as defined by the Secretary in the regulations issued under subparagraph (A).

''(C) If the Secretary determines that the performance of a person licensed in accordance with subparagraph (A) is unsatisfactory, the Secretary may, after notice and an opportunity for a hearing, revoke the license issued to such person.

''(D) In issuing licenses under this subsection, the Secretary shall give a preference to persons who are licensed or accredited veterinarians.

''(E) Licensure of a person in accordance with the requirements prescribed under this