rule. There were some of us who were for it and some of us who were against it, but I know that all of us, all 434 of his colleagues, are honored to serve with the longest-serving Member of this House, who has committed himself to health care throughout his life, as did his father. We honor him for the service he has given to our country.

Ladies and gentlemen, let us stand in honor of JOHN DINGELL.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SERRANO). Without objection, 5-minute voting will continue.

There was no objection.

RECOGNIZING 20TH ANNIVERSARY OF THE ENDING OF THE COLD WAR

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and agreeing to the resolution, H. Res. 892.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. BERMAN) that the House suspend the rules and agree to the resolution, H. Res. 892.

The question was taken.

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

RECORDED VOTE

Mr. HASTINGS of Florida. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 431, noes 1, not voting 2, as follows:

[Roll No. 883]

AYES—431

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (AK)
Young (FL)

NOES—1

Paul

NOT VOTING—2

Gingrey (GA)
Moran (VA)

□ 1357

So (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AFFORDABLE HEALTH CARE FOR AMERICA ACT

Mr. WAXMAN. Mr. Speaker, pursuant to House Resolution 903, I call up the bill (H.R. 3962) to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the amendment printed in part A of House Report 111–330, perfected by the modification printed in part B of the report is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 3962

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 DIVISIONS, TITLES, AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Care for America Act''.

(b) TABLE OF DIVISIONS, TITLES, AND SUBTITLES.—This Act is divided into divisions, titles, and subtitles as follows:

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—IMMEDIATE REFORMS
TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS
Subtitle A—General Standards
Subtitle B—Standards Guaranteeing Access to Affordable Coverage
Subtitle C—Standards Guaranteeing Access to Essential Benefits
Subtitle D—Additional Consumer Protections
Subtitle E—Governance
Subtitle F—Relation to Other Requirements; Miscellaneous
TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS
Subtitle A—Health Insurance Exchange
Subtitle B—Public Health Insurance Option

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.

(a) PURPOSE.—

(1) IN GENERAL.—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;

(C) includes sliding scale affordability credits; and

(D) initiates shared responsibility among workers, employers, and the Government;

so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and Government.

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

(c) GENERAL DEFINITIONS.—Except as otherwise provided, in this division:

(1) ACCEPTABLE COVERAGE.—The term ''acceptable coverage'' has the meaning given such term in section 302(d)(2).

(2) BASIC PLAN.—The term ''basic plan'' has the meaning given such term in section 303(c).

(3) COMMISSIONER.—The term ''Commissioner'' means the Health Choices Commissioner established under section 241.

(4) COST-SHARING.—The term ''cost-sharing'' includes deductibles, coinsurance, copayments, and similar charges, but does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(5) DEPENDENT.—The term ''dependent'' has the meaning given such term by the Commissioner and includes a spouse.

(6) EMPLOYMENT-BASED HEALTH PLAN.—The term ''employment-based health plan''—

(A) means a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974);

(B) includes such a plan that is the following:

(i) FEDERAL, STATE, AND TRIBAL GOVERNMENTAL PLANS.—A governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), including a health benefits plan offered under chapter 89 of title 5, United States Code.

(ii) CHURCH PLANS.—A church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974); and

(C) excludes coverage described in section 302(d)(2)(E) (relating to TRICARE).

(7) ENHANCED PLAN.—The term ''enhanced plan'' has the meaning given such term in section 303(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term ''essential benefits package'' is defined in section 222(a).

(9) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—The term ''Exchange-participating health benefits plan'' means a qualified health benefits plan that is offered through the Health Insurance Exchange and may be purchased directly from the entity offering the plan or through enrollment agents and brokers.

(10) FAMILY.—The term ''family'' means an individual and includes the individual's dependents.

(11) FEDERAL POVERTY LEVEL; FPL.—The terms ''Federal poverty level'' and ''FPL'' have the meaning given the term ''poverty line'' in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(12) HEALTH BENEFITS PLAN.—The term ''health benefits plan'' means health insurance coverage and an employment-based health plan and includes the public health insurance option.

(13) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' has the meaning given such term in section 2791 of the Public Health Service Act, but does not include coverage in relation to its provision of excepted benefits—

(A) described in paragraph (1) of subsection (c) of such section; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(14) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' has the meaning given such term in section 2791(b)(2) of the Public Health Service Act.

(15) HEALTH INSURANCE EXCHANGE.—The term ''Health Insurance Exchange'' means the Health Insurance Exchange established under section 301.

(16) INDIAN.—The term ''Indian'' has the meaning given such term in section 4 of the Indian Health Care Improvement Act (24 U.S.C. 1603).

(17) INDIAN HEALTH CARE PROVIDER.—The term ''Indian health care provider'' means a health care program operated by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(18) MEDICAID.—The term ''Medicaid'' means a State plan under title XIX of the Social Security Act (whether or not the plan is operating under a waiver under section 1115 of such Act).

(19) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance under Medicaid.

(20) MEDICARE.—The term ''Medicare'' means the health insurance programs under title XVIII of the Social Security Act.

(21) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(22) PLAN YEAR.—The term ''plan year'' means—

(A) with respect to an employment-based health plan, a plan year as specified under such plan; or

(B) with respect to a health benefits plan other than an employment-based health plan, a 12-month period as specified by the Commissioner.

(23) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms ''premium plan'' and ''premium-plus plan'' have the meanings given such terms in section 303(c).

(24) QHBP OFFERING ENTITY.—The terms ''QHBP offering entity'' means, with respect to a health benefits plan that is—

(A) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, except that, in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such term means such employer;

(B) health insurance coverage, the health insurance issuer offering the coverage;

(C) the public health insurance option, the Secretary of Health and Human Services;

(D) a non-Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the State or political subdivision of a State (or agency or instrumentality of such State or subdivision) which establishes or maintains such plan; or

(E) a Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the appropriate Federal official.

(25) QUALIFIED HEALTH BENEFITS PLAN.—The term ''qualified health benefits plan'' means a health benefits plan that—

(A) meets the requirements for such a plan under title II and includes the public health insurance option; and

(B) is offered by a QHBP offering entity that meets the applicable requirements of such title with respect to such plan.

(26) PUBLIC HEALTH INSURANCE OPTION.—The term ''public health insurance option'' means the public health insurance option as provided under subtitle B of title III.

(27) SERVICE AREA; PREMIUM RATING AREA.—The terms ''service area'' and ''premium rating area'' mean with respect to health insurance coverage—

(A) offered other than through the Health Insurance Exchange, such an area as established by the QHBP offering entity of such coverage in accordance with applicable State law; and

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

(28) STATE.—The term ''State'' means the 50 States and the District of Columbia and includes—

(A) for purposes of title I, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; and

(B) for purposes of titles II and III, as elected under and subject to section 346, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(29) STATE MEDICAID AGENCY.—The term ''State Medicaid agency'' means, with respect to a Medicaid plan, the single State agency responsible for administering such plan under title XIX of the Social Security Act.

(30) Y1, Y2, ETC.—The terms ''Y1'', ''Y2'', ''Y3'', ''Y4'', ''Y5'', and similar subsequently numbered terms, mean 2013 and subsequent years, respectively.

TITLE I—IMMEDIATE REFORMS

SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a temporary national high-risk pool program (in this section referred to as the ''program'') to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and, subject to subsection (h)(3)(B), ending on the date on which the Health Insurance Exchange is established.

(b) ADMINISTRATION.—The Secretary may carry out this section directly or, pursuant to agreements, grants, or contracts with States, through State high-risk pool programs provided that the requirements of this section are met. ''For a State without a high-risk pool program, the Secretary may work with the State to coordinate with other forms of coverage expansions, such as State public-private partnerships.''.

(c) ELIGIBILITY.—For purposes of this section, the term ''eligible individual'' means an individual ''who meets the requirements of subsection (i)(1)''.

(1) who—

(A) is not eligible for—

(i) benefits under title XVIII, XIX, or XXI of the Social Security Act; or

(ii) coverage under an employment-based health plan (not including coverage under a COBRA continuation provision, as defined in section 107(d)(1)); and

(B) who—

(i) is an eligible individual under section 2741(b) of the Public Health Service Act; or

(ii) is medically eligible for the program by virtue of being an individual described in subsection (d) at any time during the 6-month period ending on the date the individual applies for high-risk pool coverage under this section;

(2) who is the spouse or dependent of an individual who is described in paragraph (1);

(3) who has not had health insurance coverage or coverage under an employment-based health plan for at least the 6-month period immediately preceding the date of the individual's application for high-risk pool coverage under this section; ''or.''

(4) who on or after October 29, 2009, had employment-based retiree health coverage (as defined in subsection (i)) and the annual increase in premiums for such individual under such coverage (for any coverage period beginning on or after such date) exceeds such excessive percentage as the Secretary shall specify.

For purposes of paragraph (1)(A)(ii), a person who is in a waiting period as defined in section 2701(b)(4) of the Public Health Service Act shall not be considered to be eligible for coverage under an employment-based health plan.

(d) MEDICALLY ELIGIBLE REQUIREMENTS.—For purposes of subsection (c)(1)(B)(ii), an individual described in this subsection is an individual—

(1) who, during the 6-month period ending on the date the individual applies for high-risk pool coverage under this section applied for individual health insurance coverage and—

(A) was denied such coverage because of a preexisting condition or health status; or

(B) was offered such coverage—

(i) under terms that limit the coverage for such a preexisting condition; or

(ii) at a premium rate that is above the premium rate for high risk pool coverage under this section; or

(2) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual coverage at a premium rate above the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rating that are attributable solely to differences in age rating.

(e) ENROLLMENT.—To enroll in coverage in the program, an individual shall—

(1) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require;

(2) attest '', consistent with subsection (i)(2),'' that the individual is an eligible individual and is a resident of one of the 50 States or the District of Columbia; and

(3) if the individual had other prior health insurance coverage or coverage under an employment-based health plan during the previous 6 months, provide information as to the nature and source of such coverage and reasons for its discontinuance.

(f) PROTECTION AGAINST DUMPING RISKS BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(g) COVERED BENEFITS, COST-SHARING, PREMIUMS, AND CONSUMER PROTECTIONS.—

(1) PREMIUM.—The monthly premium charged to eligible individuals for coverage under the program—

(A) may vary by age so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1;

(B) shall be set at a level that does not exceed 125 percent of the prevailing standard rate for comparable coverage in the individual market; and

(C) shall be adjusted for geographic variation in costs.

Health insurance issuers shall provide such information as the Secretary may require to determine prevailing standard rates under this paragraph. The Secretary shall establish standard rates in consultation with the National Association of Insurance Commissioners.

(2) COVERED BENEFITS.—Covered benefits under the program shall be determined by the Secretary and shall be consistent with the basic categories in the essential benefits package described in section 222. Under such benefits package—

(A) the annual deductible for such benefits may not be higher than $1,500 for an individual or such higher amount for a family as determined by the Secretary;

(B) there may not be annual or lifetime limits; and

(C) the maximum cost-sharing with respect to an individual (or family) for a year shall not exceed $5,000 for an individual (or $10,000 for a family).

(3) NO PREEXISTING CONDITION EXCLUSION PERIODS.—No preexisting condition exclusion period shall be imposed on coverage under the program.

(4) APPEALS.—The Secretary shall establish an appeals process for individuals to appeal a determination of the Secretary—

(A) with respect to claims submitted under this section; and

(B) with respect to eligibility determinations made by the Secretary under this section.

(5) STATE CONTRIBUTION, MAINTENANCE OF EFFORT.—As a condition of providing health benefits under this section to eligible individual residing in a State—

(A) in the case of a State in which a qualified high-risk pool (as defined under section 2744(c)(2) of the Public Health Service Act) was in effect as of July 1, 2009, the Secretary shall require the State make a maintenance of effort payment each year that the high-risk pool is in effect equal to an amount not less than the amount of all sources of funding for high-risk pool coverage made by that State in the year ending July 1, 2009; and

(B) in the case of a State which required health insurance issuers to contribute to a State high-risk pool or similar arrangement for the assessment against such issuers for pool losses, the State shall maintain such a contribution arrangement among such issuers.

(6) LIMITING PROGRAM EXPENDITURES.—The Secretary shall, with respect to the program—

(A) establish procedures to protect against fraud, waste, and abuse under the program; and

(B) provide for other program integrity methods.

(7) TREATMENT AS CREDITABLE COVERAGE.—Coverage under the program shall be treated, for purposes of applying the definition of ''creditable coverage'' under the provisions of title XXVII of the Public Health Service Act, part 6 of subtitle B of title I of Employee Retirement Income Security Act of 1974, and chapter 100 of the Internal Revenue Code of 1986 (and any other provision of law that references such provisions) in the same manner as if it were coverage under a State health benefits risk pool described in section 2701(c)(1)(G) of the Public Health Service Act.

(h) FUNDING; TERMINATION OF AUTHORITY.—

(1) IN GENERAL.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and administrative costs of) the high-risk pool under this section in excess of the premiums collected with respect to eligible individuals enrolled in the high-risk pool. Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for payment of expenses of the high-risk pool will be less than the amount of the expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit, including reducing benefits, increasing premiums, or establishing waiting lists.

(3) TERMINATION OF AUTHORITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), coverage of eligible individuals under a high-risk pool shall terminate as of the date on which the Health Insurance Exchange is established.

(B) TRANSITION TO EXCHANGE.—The Secretary shall develop procedures to provide for the transition of eligible individuals who are enrolled in health insurance coverage offered through a high-risk pool established under this section to be enrolled in acceptable coverage. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage offered through such a high-risk pool beyond 2012 if the Secretary determines necessary to avoid such a lapse.

(i) APPLICATION AND VERIFICATION OF REQUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE IN THE UNITED STATES.—

(1) REQUIREMENT.—No individual shall be an eligible individual under this section unless the individual is a citizen or national of the United States or is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act.)

(2) APPLICATION OF VERIFICATION PROCESS FOR AFFORDABILITY CREDIT.—The provisions of paragraphs (4) (other than subparagraphs (F) and (H)(i)) and (5)(A) of section 341(b), and of subsections (v) (other than paragraph (3)) and (x) of section 205 of the Social Security Act, shall apply to the verification of eligibility of an eligible individual by the Secretary (or by a State agency approved by the Secretary) for benefits under this section in the same manner as such provisions apply to the verification of eligibility of a affordable credit eligible individual for affordability credits by the Commissioner under section 341(b). The agreement referred to in section 205(v)(2)(A) of the Social Security Act (as applied under this paragraph) shall also provide for funding, to be payable for the amount made available under subsection (h)(1), to the Commissioner of Social Security in such amount as is agreed to by such Commissioner and the Secretary.

(j) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—In this section, the term ''employment-based retiree health coverage'' means health insurance or other coverage of health care costs (whether provided by voluntary insurance or pursuant to statutory or contractual obligation) for individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

SEC. 102. ENSURING VALUE AND LOWER PREMIUMS.

(a) GROUP HEALTH INSURANCE COVERAGE.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.

''(a) IN GENERAL.—Each health insurance issuer that offers health insurance coverage in the small or large group market shall provide that for any plan year in which the coverage has a medical loss ratio below a level specified by the Secretary (but not less than 85 percent), the issuer shall provide in a manner specified by the Secretary for rebates to enrollees of the amount by which the issuer's medical loss ratio is less than the level so specified.

''(b) IMPLEMENTATION.—The Secretary shall establish a uniform definition of medical loss ratio and methodology for determining how to calculate it based on the average medical loss ratio in a health insurance issuer's book of business for the small and large group market. Such methodology shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. In determining the medical loss ratio, the Secretary shall exclude State taxes and licensing or regulatory fees. Such methodology shall be designed and exceptions shall be established to ensure adequate participation by health insurance issuers, competition in the health insurance market, and value for consumers so that their premiums are used for services.

''(c) SUNSET.—Subsections (a) and (b) shall not apply to health insurance coverage on and after the first date that health insurance coverage is offered through the Health Insurance Exchange.''.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Such title is further amended by inserting after section 2753 the following new section:

''SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

''The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the same manner as such provisions apply to health insurance coverage offered in the small or large group market except to the extent the Secretary determines that the application of such section may destabilize the existing individual market.''.

(c) IMMEDIATE IMPLEMENTATION.—The amendments made by this section shall apply in the group and individual market for plan years beginning on or after January 1, 2010, or as soon as practicable after such date.

SEC. 103. ENDING HEALTH INSURANCE RESCISSION ABUSE.

(a) CLARIFICATION REGARDING APPLICATION OF GUARANTEED RENEWABILITY OF INDIVIDUAL

AND GROUP HEALTH INSURANCE COVERAGE.—Sections 2712 and 2742 of the Public Health Service Act (42 U.S.C. 300gg–12, 300gg–42) are each amended—

(1) in its heading, by inserting ''**AND CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**'' after ''**GUARANTEED RENEWABILITY**''; and

(2) in subsection (a), by inserting '', including without rescission,'' after ''continue in force''.

(b) SECRETARIAL GUIDANCE REGARDING RESCISSIONS.—

(1) GROUP HEALTH INSURANCE MARKET.—Section 2712 of such Act (42 U.S.C. 300gg–12) is amended by adding at the end the following:

''(f) RESCISSION.—A health insurance issuer may rescind group health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.''.

(2) INDIVIDUAL HEALTH MARKET.—Section 2742 of such Act (42 U.S.C. 300gg–42) is amended by adding at the end the following:

''(f) RESCISSION.—A health insurance issuer may rescind individual health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.''.

(3) GUIDANCE.—The Secretary of Health and Human Services, no later than 90 days after the date of the enactment of this Act, shall issue guidance implementing the amendments made by paragraphs (1) and (2), including procedures for independent, external third-party review.

(c) OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CERTAIN CASES.—

(1) INDIVIDUAL MARKET.—Subpart 1 of part B of title XXVII of such Act (42 U.S.C. 300gg–41 et seq.) is amended by adding at the end the following:

''SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

''(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to rescind health insurance coverage for an individual in the individual market, before such rescission may take effect the issuer shall provide the individual with notice of such proposed rescission and an opportunity for a review of such determination by an independent, external third-party under procedures specified by the Secretary under section 2742(f).

''(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third-party of a rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be rescinded under the guidance issued by the Secretary under section 2742(f).''.

(2) APPLICATION TO GROUP HEALTH INSURANCE.—Such title is further amended by adding after section 2702 the following new section:

''SEC. 2703. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

''The provisions of section 2746 shall apply to group health insurance coverage in the same manner as such provisions apply to individual health insurance coverage, except that any reference to section 2742(f) is deemed a reference to section 2712(f).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to rescissions occurring on and after July 1, 2010, with respect to health insurance coverage issued before, on, or after such date.

SEC. 104. SUNSHINE ON PRICE GOUGING BY HEALTH INSURANCE ISSUERS.

(a) INITIAL PREMIUM REVIEW PROCESS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in conjunction with States, shall establish a process for the annual review, beginning with 2010 and subject to subsection (c)(3)(A), of increases in premiums for health insurance coverage.

(2) JUSTIFICATION AND DISCLOSURE.—Such process shall require health insurance issuers to submit a justification for any premium increase prior to implementation of the increase. Such issuers shall prominently post such information on their websites. The Secretary shall ensure the public disclosure of information on such increase and justifications for all health insurance issuers.

(b) CONTINUING PREMIUM REVIEW PROCESS.—

(1) INFORMING COMMISSIONER OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

(A) provide the Health Choices commissioner with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

(B) make recommendations, as appropriate, to such Commissioner about whether particular health insurance issuers should be excluded from participation in the Health Insurance Exchange based on a pattern of excessive or unjustified premium increases.

(2) COMMISSIONER AUTHORITY REGARDING EXCHANGE PARTICIPATION.—In making determinations concerning entering into contracts with QHBP offering entities for the offering of Exchange-participating health plans under section 304, the Commissioner shall take into account the information and recommendations provided under paragraph (1).

(3) MONITORING BY COMMISSIONER OF PREMIUM INCREASES.—

(A) IN GENERAL.—Beginning in 2014, the Commissioner, in conjunction with the States and in place of the monitoring by the Secretary under subsection (a)(1) and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered inside the Health Insurance Exchange under section 304 and outside of the Exchange.

(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 302(e)(4) whether to make additional larger employers eligible to participate in the Health Insurance Exchange, the Commissioner shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(c) GRANTS IN SUPPORT OF PROCESS.—

(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program of grants to States during the 5-year period beginning with 2010 to assist them in carrying out subsection (a), including—

(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

(B) in providing information and recommendations to the Commissioner under subsection (b)(1).

(2) FUNDING.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $1,000,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION GRANTS.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under title II.

(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.

SEC. 105. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

(a) UNDER GROUP HEALTH PLANS.—

(1) PHSA.—Title XXVII of the Public Health Service Act is amended by inserting after section 2702 the following new section:

''SEC. 2703. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

''(1) is under 27 years of age; and

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section, section 2746, or section 704 of the Employee Retirement Income Security Act of 1974) under any health insurance coverage or group health plan.

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(A) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 703 the following new section:

''SEC. 704. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

''(1) is under 27 years of age; and

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section) under any health insurance coverage or group health plan.

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage

from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

(B) CLERICAL AMENDMENT.—The table of contents of such Act is amended by inserting after the item relating to section 703 the following new item:

''Sec. 704. Requiring the option of extension of dependent coverage for uninsured young adults.''.

(3) IRC.—

(A) IN GENERAL.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9804. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan, an individual who (but for age) would be treated as a dependent child of the participant under such plan and who—

''(1) is under 27 years of age; and

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section, section 704 of the Employee Retirement Income Security Act of 1974, or section 2704 or 2746 of the Public Health Service Act) under any health insurance coverage or group health plan.

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

(B) CLERICAL AMENDMENT.—The table of sections of such chapter is amended by inserting after the item relating to section 9803 the following:

''Sec. 9804. Requiring the option of extension of dependent coverage for uninsured young adults.''.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Title XXVII of the Public Health Service Act is amended by inserting after section 2745 the following new section:

''SEC. 2746. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''The provisions of section 2703 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—The amendments made by subsection (a) shall apply to group health plans for plan years beginning on or after January 1, 2010.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2746 of the Public Health Service Act, as inserted by subsection (b), shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2010.

SEC. 106. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS IN GROUP HEALTH PLANS IN ADVANCE OF APPLICABILITY OF NEW PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking ''6-month period'' and inserting ''30-day period''.

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 701(a)(2) of such Act (29 U.S.C. 1181(a)(2)) is amended by striking ''12 months'' and inserting ''3 months'', and by striking ''18 months'' and inserting ''9 months''.

(3) SUNSET OF INTERIM LIMITATION.—Section 701 of such Act (29 U.S.C. 1181) is amended by adding at the end the following new subsection:

''(h) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).''.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 9801(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''6-month period'' and inserting ''30-day period''.

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 9801(a)(2) of such Code is amended by striking ''12 months'' and inserting ''3 months'', and by striking ''18 months'' and inserting ''9 months''.

(3) SUNSET OF INTERIM LIMITATION.—Section 9801 of such Code is amended by adding at the end the following new subsection:

''(g) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the ''Affordable Health Care for America Act'' (relating to prohibiting preexisting condition exclusions).''.

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)) is amended by striking ''6-month period'' and inserting ''30-day period''.

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 2701(a)(2) of such Act (42 U.S.C. 300gg(a)(2)) is amended by striking ''12 months'' and inserting ''3 months'', and by striking ''18 months'' and inserting ''9 months''.

(3) SUNSET OF INTERIM LIMITATION.—Section 2701 of such Act (42 U.S.C. 300gg) is amended by adding at the end the following new subsection:

''(h) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).''.

(4) MISCELLANEOUS TECHNICAL AMENDMENT.—Section 2702(a)(2) of such Act (42 U.S.C. 300gg–1) is amended by striking ''701'' and inserting ''2701''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 2010.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act);

(B) 3 years after the date of the enactment of this Act.

SEC. 107. PROHIBITING ACTS OF DOMESTIC VIOLENCE FROM BEING TREATED AS PREEXISTING CONDITIONS.

(a) ERISA.—Section 701(d)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.) is amended—

(1) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(2) by inserting ''or domestic violence'' after ''relating to pregnancy''.

(b) PHSA.—

(1) GROUP MARKET.—Section 2701(d)(3) of the Public Health Service Act (42 U.S.C. 300gg(d)(3)) is amended—

(A) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(B) by inserting ''or domestic violence'' after ''relating to pregnancy''.

(2) INDIVIDUAL MARKET.—Title XXVII of such Act is amended by inserting after section 2753 the following new section:

''SEC. 2754. PROHIBITION ON DOMESTIC VIOLENCE AS PREEXISTING CONDITION.

''A health insurance issuer offering health insurance coverage in the individual market may not, on the basis of domestic violence, impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.''.

(c) IRC.—Section 9801(d)(3) of the Internal Revenue Code of 1986 is amended—

(1) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(2) by inserting ''or domestic violence'' after ''relating to pregnancy''.

(d) EFFECTIVE DATES.—

(1) Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) The amendment made by subsection (b)(2) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

SEC. 108. ENDING HEALTH INSURANCE DENIALS AND DELAYS OF NECESSARY TREATMENT FOR CHILDREN WITH DEFORMITIES.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 715. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

''(2) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) (other than paragraph (3)) with respect to the requirements of this section.''.

(2) CONFORMING AMENDMENT.—

(A) Subsection (c) of section 731 of such Act is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

(B) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9814. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—A group health plan that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

''(b) TREATMENT DEFINED.—

''(1) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(A) procedures that do not materially affect the function of the body part being treated, and

''(B) procedures for secondary conditions and follow-up treatment.

''(2) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code is amended by adding at the end the following new item:

''Sec. 9814. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

''(2) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 715(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(2) INDIVIDUAL HEALTH INSURANCE.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 161(b), is further amended by adding at the end the following new section:

''SEC. 2755. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(B) Section 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2755''.

(d) EFFECTIVE DATES.—

(1) The amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) The amendment made by subsection (c)(2) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(e) COORDINATION.—Section 104(1) of the Health Insurance Portability and Accountability Act of 1996 is amended by striking ''(and the amendments made by this subtitle and section 401)'' and inserting '', part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

SEC. 109. ELIMINATION OF LIFETIME LIMITS.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 108, is amended by adding at the end the following:

''SEC. 716. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan or coverage.

''(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Elimination of lifetime aggregate limits.''.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 108(b), is amended by adding at the end the following new section:

''SEC. 9815. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

''(a) IN GENERAL.—A group health plan may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan.

''(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan a dollar limitation on the total amount that may be paid with respect to such benefits under the plan with respect to an individual or other coverage unit on a lifetime basis.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code, as amended by section 108(b), is amended by adding at the end the following new item:

''Sec. 9854. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(c) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) as amended by section 108(c)(1), is amended by adding at the end the following:

''SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan or coverage.

''(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.''.

(2) INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.), as amended by section 108(c)(2), is amended by adding at the end the following:

''SEC. 2756. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

''The provisions of section 2709 shall apply to health insurance coverage offered by a health insurance issuer in the individual

market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(d) EFFECTIVE DATES.—

(1) The amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) The amendment made by subsection (c)(2) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

SEC. 110. PROHIBITION AGAINST POSTRETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by sections 108 and 109, is amended by inserting after section 716 the following new section:

''SEC. 717. PROTECTION AGAINST POSTRETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

''(a) IN GENERAL.—Every group health plan shall contain a provision which expressly bars the plan, or any fiduciary of the plan, from reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement unless such reduction is also made with respect to active participants. Nothing in this section shall prohibit a plan from enforcing a total aggregate cap on amounts paid for retiree health coverage that is part of the plan at the time of retirement.

''(b) NO REDUCTION.—Notwithstanding that a group health plan may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or the participant's beneficiary under the terms of the plan if such reduction of benefits occurs after the date the participant retired for purposes of the plan and reduces benefits that were provided to the participant, or the participant's beneficiary, as of the date the participant retired unless such reduction is also made with respect to active participants.

''(c) REDUCTION DESCRIBED.— For purposes of this section, a reduction in benefits—

''(1) with respect to premiums occurs under a group health plan when a participant's (or beneficiary's) share of the total premium (or, in the case of a self-insured plan, the costs of coverage) of the plan substantially increases; or

''(2) with respect to other cost-sharing and benefits under a group health plan occurs when there is a substantial decrease in the actuarial value of the benefit package under the plan.

For purposes of this section, the term 'substantial' means an increase in the total premium share or a decrease in the actuarial value of the benefit package that is greater than 5 percent.''

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act, as amended by sections 108 and 109, is amended by inserting after the item relating to section 716 the following new item:

''Sec. 717. Protection against postretirement reduction of retiree health benefits.''.

(c) WAIVER.—An employer may, in a form and manner which shall be prescribed by the Secretary of Labor, apply for a waiver from this provision if the employer can reasonably demonstrate that meeting the requirements of this section would impose an undue hardship on the employer.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 111. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a temporary reinsurance program (in this section referred to as the ''reinsurance program'') to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

(2) DEFINITIONS.—For purposes of this section:

(A) The term ''eligible employment-based plan'' means a group health plan or employment-based health plan that—

(i) is —

(I) maintained by one or more employers (including without limitation any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing), former employers or employee organizations or associations, or a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to retirees.

(B) The term ''health benefits'' means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded or delivered through the purchase of insurance or otherwise.

(C) The term ''participating employment-based plan'' means an eligible employment-based plan that is participating in the reinsurance program.

(D) The term ''retiree'' means, with respect to a participating employment-benefit plan, an individual who—

(i) is 55 years of age or older;

(ii) is not eligible for coverage under title XVIII of the Social Security Act; and

(iii) is not an active employee of an employer maintaining the plan or of any employer that makes or has made substantial contributions to fund such plan.

(E) The term ''Secretary'' means Secretary of Health and Human Services.

(b) PARTICIPATION.—To be eligible to participate in the reinsurance program, an eligible employment-based plan shall submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—Under the reinsurance program, a participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) BASIS FOR CLAIMS.—Each claim submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the appropriate employment based health benefits provided to a retiree or to the spouse, surviving spouse, or dependent of a retiree. In determining the amount of any claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefits. For purposes of calculating the amount of any claim, the costs paid by the retiree or by the spouse, surviving spouse, or dependent of the retiree in the form of deductibles, copayments, and coinsurance shall be included along with the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS AND LIMIT.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceeds $15,000, but is less than $90,000. Such amounts shall be adjusted each year based on the percentage increase in the medical care component of the Consumer Price Index (rounded to the nearest multiple of $1,000) for the year involved.

(3) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall only be used to reduce the costs of health care provided by the plan by reducing premium costs for the employer or employee association maintaining the plan, and reducing premium contributions, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries. Where the benefits are provided by an employer to members of a represented bargaining unit, the allocation of payments among these purposes shall be subject to collective bargaining. Amounts paid to the plan under this subsection shall not be used as general revenues by the employer or employee association maintaining the plan or for any other purposes. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

(4) APPEALS AND PROGRAM PROTECTIONS.—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(5) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that they are in compliance with the requirements of this section.

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ''Retiree Reserve Trust Fund'' (referred to in this section as the ''Trust Fund''), that shall consist of such amounts as may be appropriated or credited to the Trust Fund as provided for in this subsection to enable the Secretary to carry out the reinsurance program. Such amounts shall remain available until expended.

(B) FUNDING.—There are hereby appropriated to the Trust Fund, out of any moneys in the Treasury not otherwise appropriated, an amount requested by the Secretary as necessary to carry out this section, except that the total of all such amounts requested shall not exceed $10,000,000,000.

(C) APPROPRIATIONS FROM THE TRUST FUND.—

(i) IN GENERAL.—Amounts in the Trust Fund are appropriated to provide funding to carry out the reinsurance program and shall be used to carry out such program.

(ii) LIMITATION TO AVAILABLE FUNDS.—The Secretary has the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under the reinsurance program in order to ensure that expenditures under the reinsurance program do not exceed the funds available under this subsection.

SEC. 112. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

(1) IN GENERAL.—For purposes of this section, the Secretaries of Health and Human Services and Labor shall jointly award wellness grants as determined under this section. Wellness program grants shall be awarded to small employers (as defined by the Secretary) for any plan year in an amount equal to 50 percent of the costs paid or incurred by such employers in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(2) LIMITATIONS.—

(A) PERIOD.—A wellness grant awarded to an employer under this section shall be for up to 3 years.

(B) AMOUNT.—The amount of the grant under paragraph (1) for an employer shall not exceed—

(i) the product of $150 and the number of employees of the employer for any plan year; and

(ii) $50,000 for the entire period of the grant.

(b) QUALIFIED WELLNESS PROGRAM.—For purposes of this section:

(1) QUALIFIED WELLNESS PROGRAM.—The term ''qualified wellness program'' means a program that —

(A) includes any 3 wellness components described in subsection (c); and

(B) is to be certified jointly by the Secretary of Health and Human Services and the Secretary of Labor, in coordination with the Director of the Centers for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

(i) is consistent with evidence-based research and best practices, as identified by persons with expertise in employer health promotion and wellness programs;

(ii) includes multiple, evidence-based strategies which are based on the existing and emerging research and careful scientific reviews, including the Guide to Community Preventative Services, the Guide to Clinical Preventative Services, and the National Registry for Effective Programs, and

(iii) includes strategies which focus on prevention and support for employee populations at risk of poor health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies shall jointly establish procedures for periodic review, evaluation, and update of the programs under this subsection.

(3) HEALTH LITERACY AND ACCESSIBILITY.—The Secretaries of Health and Human Services and Labor shall jointly, as part of the certification process—

(A) ensure that employers make the programs culturally competent, physically and programmatically accessible (including for individuals with disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with low literacy skills, limited English and from underserved populations; and

(C) require the Secretaries to compile and disseminate to employer health plans information on model health literacy curricula, instructional programs, and effective intervention strategies.

(c) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow-up measures.

(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for the active engagement of employees in worksite wellness programs through worksite assessments and program planning, onsite delivery, evaluation, and improvement efforts.

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which encourages healthy living through counseling, seminars, on-line programs, self-help materials, or other programs which provide technical assistance and problem solving skills. Such component may include programs relating to—

(A) tobacco use;

(B) obesity;

(C) stress management;

(D) physical fitness;

(E) nutrition;

(F) substance abuse;

(G) depression; and

(H) mental health promotion.

(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

(A) ON-SITE POLICIES.—Policies and services at the worksite which promote a healthy lifestyle, including policies relating to—

(i) tobacco use at the worksite;

(ii) the nutrition of food available at the worksite through cafeterias and vending options;

(iii) minimizing stress and promoting positive mental health in the workplace; and

(iv) the encouragement of physical activity before, during, and after work hours.

(d) PARTICIPATION REQUIREMENT.—No grant shall be allowed under subsection (a) unless the Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies, jointly certify, as a part of any certification described in subsection (b), that each wellness program component of the qualified wellness program—

(1) shall be available to all employees of the employer;

(2) shall not mandate participation by employees; and

(3) may provide a financial reward for participation of an individual in such program so long as such reward is not tied to the premium or cost-sharing of the individual under the health benefits plan.

(e) PRIVACY PROTECTIONS.—Data gathered for purposes of the employer wellness program may be used solely for the purposes of administering the program. The Secretaries of Health and Human Services and Labor shall develop standards to ensure such data remain confidential and are not used for purposes beyond those for administering the program.

(f) CERTAIN COSTS NOT INCLUDED.—For purposes of this section, costs paid or incurred by an employer for food or health insurance shall not be taken into account under subsection (a).

(g) OUTREACH.—The Secretaries of Health and Human Services and Labor, in conjunction with other appropriate agencies and members of the business community, shall jointly institute an outreach program to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs according to recognized and promising practices and on how to measure the success of implemented programs.

(h) EFFECTIVE DATE.—This section shall take effect on July 1, 2010.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 113. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) IN GENERAL.—In the case of any individual who is, under a COBRA continuation coverage provision, covered under COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated under the terms of such provision for any reason other than the expiration of a period of a specified number of months shall, notwithstanding such provision and subject to subsection (b), extend to the earlier of the date on which such individual becomes eligible for acceptable coverage or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

(2) NOTICE.—As soon as practicable after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide or administer the COBRA continuation coverage involved, provide rules setting forth the form and manner in which prompt notice to individuals of the continued availability of COBRA continuation coverage to such individuals under paragraph (1).

(b) CONTINUED EFFECT OF OTHER TERMINATING EVENTS.—Notwithstanding subsection (a), any required period of COBRA continuation coverage which is extended under such subsection shall terminate upon the occurrence, prior to the date of termination otherwise provided in such subsection, of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of a specified number of months.

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provision of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section solely by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired.

(d) DEFINITIONS.—For purposes of this section—

(1) COBRA CONTINUATION COVERAGE.—The term ''COBRA continuation coverage''

means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986.

(2) COBRA CONTINUATION PROVISION.—The term ''COBRA continuation provision'' means the provisions of law described in paragraph (1).

SEC. 114. STATE HEALTH ACCESS PROGRAM GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide grants to States (as defined for purposes of title XIX of the Social Security Act) to establish programs to expand access to affordable health care coverage for the uninsured populations in that State in a manner consistent with reforms to take effect under this division in Y1.

(b) TYPES OF PROGRAMS.—The types of programs for which grants are available under subsection (a) include the following:

(1) STATE INSURANCE EXCHANGES.—State insurance exchanges that develop new, less expensive, portable benefit packages for small employers and part-time and seasonal workers.

(2) COMMUNITY COVERAGE PROGRAM.—Community coverage with shared responsibility between employers, governmental or nonprofit entity, and the individual.

(3) REINSURANCE PLAN PROGRAM.—Reinsurance plans that subsidize a certain share of carrier losses within a certain risk corridor health insurance premium assistance.

(4) TRANSPARENT MARKETPLACE PROGRAM.—Transparent marketplace that provides an organized structure for the sale of insurance products such as a Web exchange or portal.

(5) AUTOMATED ENROLLMENT PROGRAM.—Statewide or automated enrollment systems for public assistance programs.

(6) INNOVATIVE STRATEGIES.—Innovative strategies to insure low-income childless adults.

(7) PURCHASING COLLABORATIVES.—Not-for-profit business, consumer collaborative that provides direct contract health care service purchasing options for group plan sponsors.

(c) ELIGIBILITY AND ADMINISTRATION.—

(1) IMPLEMENTATION OF KEY STATUTORY OR REGULATORY CHANGES.—In order to be awarded a grant under this section for a program, a State shall demonstrate that—

(A) it has achieved the key State and local statutory or regulatory changes required to begin implementing the new program within 1 year after the initiation of funding under the grant; and

(B) it will be able to sustain the program without Federal funding after the end of the period of the grant.

(2) INELIGIBILITY.—A State that has already developed a comprehensive health insurance access program is not eligible for a grant under this section.

(3) APPLICATION REQUIRED.—No State shall receive a grant under this section unless the State has approved by the Secretary such an application, in such form and manner as the Secretary specifies.

(4) ADMINISTRATION BASED ON CURRENT PROGRAM.—The program under this section is intended to build on the State Health Access Program funded under the Omnibus Appropriations Act, 2009 (Public Law 111–8).

(d) FUNDING LIMITATIONS.—

(1) IN GENERAL.—A grant under this section shall—

(A) only be available for expenditures before Y1; and

(B) only be used to supplement, and not supplant, funds otherwise provided.

(2) MATCHING FUND REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), no grant may be awarded to a State unless the State demonstrates the seriousness of its effort by matching at least 20 percent of the grant amount through non-Federal resources, which may be a combination of State, local, private dollars from insurers, providers, and other private organizations.

(B) WAIVER.—The Secretary may waive the requirement of subparagraph (A) if the State demonstrates to the Secretary financial hardship in complying with such requirement.

(e) STUDY.—The Secretary shall review, study, and benchmark the progress and results of the programs funded under this section.

(f) REPORT.—Each State receiving a grant under this section shall submit to the Secretary a report on best practices and lessons learned through the grant to inform the health reform coverage expansions under this division beginning in Y1.

(g) FUNDING.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 115. ADMINISTRATIVE SIMPLIFICATION.

(a) STANDARDIZING ELECTRONIC ADMINISTRATIVE TRANSACTIONS.—

(1) IN GENERAL.—Part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) is amended by inserting after section 1173 the following new sections:

''SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

''(a) STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

''(1) IN GENERAL.—The Secretary shall adopt and regularly update standards consistent with the goals described in paragraph (2).

''(2) GOALS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—The goals for standards under paragraph (1) are that such standards shall, to the extent practicable—

''(A) be unique with no conflicting or redundant standards;

''(B) be authoritative, permitting no additions or constraints for electronic transactions, including companion guides;

''(C) be comprehensive, efficient and robust, requiring minimal augmentation by paper transactions or clarification by further communications;

''(D) enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician at a specific facility, on a specific date or range of dates, include utilization of a machine-readable health plan beneficiary identification card or similar mechanism;

''(E) enable, where feasible, near real-time adjudication of claims;

''(F) provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction deemed appropriate by the Secretary;

''(G) describe all data elements (such as reason and remark codes) in unambiguous terms, not permit optional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions except where required by (or to implement) State or Federal law or to protect against fraud and abuse; and

''(H) harmonize all common data elements across administrative and clinical transaction standards.

''(3) TIME FOR ADOPTION.—Not later than 2 years after the date of the enactment of this section, the Secretary shall adopt standards under this section by interim, final rule.

''(4) REQUIREMENTS FOR SPECIFIC STANDARDS.—The standards under this section shall be developed, adopted, and enforced so as to—

''(A) clarify, refine, complete, and expand, as needed, the standards required under section 1173;

''(B) require paper versions of standardized transactions to comply with the same standards as to data content such that a fully compliant, equivalent electronic transaction can be populated from the data from a paper version;

''(C) enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice;

''(D) require timely and transparent claim and denial management processes, including uniform claim edits, uniform reason and remark denial codes, tracking, adjudication, and appeal processing;

''(E) require the use of a standard electronic transaction with which health care providers may quickly and efficiently enroll with a health plan to conduct the other electronic transactions provided for in this part; and

''(F) provide for other requirements relating to administrative simplification as identified by the Secretary, in consultation with stakeholders.

''(5) BUILDING ON EXISTING STANDARDS.—In adopting the standards under this section, the Secretary shall consider existing and planned standards.

''(6) IMPLEMENTATION AND ENFORCEMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

''(A) a process and timeframe with milestones for developing the complete set of standards;

''(B) a proposal for accommodating necessary changes between version changes and a process for upgrading standards as often as annually by interim, final rulemaking;

''(C) programs to provide incentives for, and ease the burden of, implementation for certain health care providers, with special consideration given to such providers serving rural or underserved areas and ensure coordination with standards, implementation specifications, and certification criteria being adopted under the HITECH Act;

''(D) programs to provide incentives for, and ease the burden of, health care providers who volunteer to participate in the process of setting standards for electronic transactions;

''(E) an estimate of total funds needed to ensure timely completion of the implementation plan; and

''(F) an enforcement process that includes timely investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for noncompliance consistent with existing laws and regulations, and a fair and reasonable appeals process building off of enforcement provisions under this part, and concurrent State enforcement jurisdiction.

The Secretary may promulgate an annual audit and certification process to ensure that all health plans and clearinghouses are

both syntactically and functionally compliant with all the standard transactions mandated pursuant to the administrative simplification provisions of this part and the Health Insurance Portability and Accountability Act of 1996.

''(b) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would violate State or Federal law.

''(c) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are used and disclosed in a manner that meets the HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), including any privacy or security standard adopted under section 3004 of such Act.

''SEC. 1173B. INTERIM COMPANION GUIDES, INCLUDING OPERATING RULES.

''(a) IN GENERAL.—The Secretary shall adopt a single, binding, comprehensive companion guide, that includes operating rules for each X12 Version 5010 transaction described in section 1173(a)(2), to be effective until the new version of these transactions which comply with section 1173A are adopted and implemented.

''(b) COMPANION GUIDE AND OPERATING RULES DEVELOPMENT.—In adopting such interim companion guide and rules, the Secretary shall comply with section 1172, except that a nonprofit entity that meets the following criteria shall also be consulted:

''(1) The entity focuses its mission on administrative simplification.

''(2) The entity uses a multistakeholder process that creates consensus-based companion guides, including operating rules using a voting process that ensures balanced representation by the critical stakeholders (including health plans and health care providers) so that no one group dominates the entity and shall include others such as standards development organizations, and relevant Federal or State agencies.

''(3) The entity has in place a public set of guiding principles that ensure the companion guide and operating rules and process are open and transparent.

''(4) The entity coordinates its activities with the HIT Policy Committee, and the HIT Standards Committee (established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

''(5) The entity incorporates the standards issued under Health Insurance Portability and Accountability Act of 1996 and this part, and in developing the companion guide and operating rules does not change the definition, data condition or use of a data element or segment in a standard, add any elements or segments to the maximum defined data set, use any codes or data elements that are either marked 'not used' in the standard's implementation specifications or are not in the standard's implementation specifications, or change the meaning or intent of the standard's implementation specifications.

''(6) The entity uses existing market research and proven best practices.

''(7) The entity has a set of measures that allow for the evaluation of their market impact and public reporting of aggregate stakeholder impact.

''(8) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(9) The entity allows for public reviews and comment on updates of the companion guide, including the operating rules.

''(c) IMPLEMENTATION.—The Secretary shall adopt a single, binding companion guide, including operating rules under this section, for each transaction, to become effective with the X12 Version 5010 transaction implementation, or as soon thereafter as feasible. The companion guide, including operating rules for the transactions for eligibility for health plan and health claims status under this section shall be adopted not later than October 1, 2011, in a manner such that such set of rules is effective beginning not later than January 1, 2013. The companion guide, including operating rules for the remainder of the transactions described in section 1173(a)(2) shall be adopted not later than October 1, 2012, in a manner such that such set of rules is effective beginning not later than January 1, 2014.''.

(2) DEFINITIONS.—Section 1171 of such Act (42 U.S.C. 1320d) is amended—

(A) in paragraph (1), by inserting '', and associated operational guidelines and instructions, as determined appropriate by the Secretary'' after ''medical procedure codes''; and

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

''(10) OPERATING RULES.—The term 'operating rules' means business rules for using and processing transactions, such as service level requirements, which do not impact the implementation specifications or other data content requirements.''.

(3) CONFORMING AMENDMENT.—Section 1179(a) of such Act (42 U.S.C. 1320d–8(a)) is amended, in the matter before paragraph (1)—

(A) by inserting ''on behalf of an individual'' after ''1978)''; and

(B) by inserting ''on behalf of an individual'' after ''for a financial institution'' and

(b) STANDARDS FOR CLAIMS ATTACHMENTS AND COORDINATION OF BENEFITS.—

(1) STANDARD FOR HEALTH CLAIMS ATTACHMENTS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate an interim, final rule to establish a standard for health claims attachment transaction described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d–2(a)(2)(B)) and coordination of benefits.

(2) REVISION IN PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS.—

(A) IN GENERAL.—Section 1179 of the Social Security Act (42 U.S.C. 1320d–8) is amended, in the matter before paragraph (1)—

(i) by striking ''or is engaged'' and inserting ''and is engaged''; and

(ii) by inserting ''(other than as a business associate for a covered entity)'' after ''for a financial institution''.

(B) COMPLIANCE DATE.—The amendments made by subparagraph (A) shall apply to transactions occurring on or after such date (not later than January 1, 2014) as the Secretary of Health and Human Services shall specify.

(c) STANDARDS FOR FIRST REPORT OF INJURY.—Not later than January 1, 2014, the Secretary of Health and Human Services shall promulgate an interim final rule to establish a standard for the first report of injury transaction described in section 1173(a)(2)(G) of the Social Security Act (42 U.S.C. 1320d–2(a)(2)(G)).

(d) UNIQUE HEALTH PLAN IDENTIFIER.—Not later October 1, 2012, the Secretary of Health and Human Services shall promulgate an interim final rule to establish a unique health plan identifier described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b)) based on the input of the National Committee of Vital and Health Statistics and consultation with health plans, health care providers, and other interested parties.

(e) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) subject to subsection (h), not later than January 1, 2015, for which the payment is other than by electronic funds transfer (EFT) so long as the Secretary has adopted and implemented a standard for electronic funds transfer under section 1173A.''.

(f) EXPANSION OF PENALTIES.—Section 1176 of such Act (42 U.S.C. 1320d–5) is amended by adding at the end the following new subsection:

''(c) EXPANSION OF PENALTY AUTHORITY.—The Secretary may, in addition to the penalties provided under subsections (a) and (b), provide for the imposition of penalties for violations of this part that are comparable—

''(1) in the case of health plans, to the sanctions the Secretary is authorized to impose under part C or D of title XVIII in the case of a plan that violates a provision of such part; or

''(2) in the case of a health care provider, to the sanctions the Secretary is authorized to impose under part A, B, or D of title XVIII in the case of a health care provider that violations a provision of such part with respect to that provider.''.

TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 201. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

(a) PURPOSE.—The purpose of this title is to establish standards to ensure that new health insurance coverage and employment-based health plans that are offered meet standards guaranteeing access to affordable coverage, essential benefits, and other consumer protections.

(b) REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS.—On or after the first day of Y1, a health benefits plan shall not be a qualified health benefits plan under this division unless the plan meets the applicable requirements of the following subtitles for the type of plan and plan year involved:

(1) Subtitle B (relating to affordable coverage).

(2) Subtitle C (relating to essential benefits).

(3) Subtitle D (relating to consumer protection).

(c) TERMINOLOGY.—In this division:

(1) ENROLLMENT IN EMPLOYMENT-BASED HEALTH PLANS.—An individual shall be treated as being ''enrolled'' in an employment-based health plan if the individual is a participant or beneficiary (as such terms are defined in section 3(7) and 3(8), respectively, of the Employee Retirement Income Security Act of 1974) in such plan.

(2) INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.—The terms ''individual health insurance coverage'' and ''group health insurance coverage'' mean health insurance coverage offered in the individual market or large or small group market, respectively, as defined in section 2791 of the Public Health Service Act.

(d) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Commissioner may permit a qualified health benefits plan to provide coverage through a qualified direct primary care medical home plan so long as the qualified health benefits plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the QHBP offering entity.

SEC. 202. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) GRANDFATHERED HEALTH INSURANCE COVERAGE DEFINED.—Subject to the succeeding provisions of this section, for purposes of establishing acceptable coverage under this division, the term ''grandfathered health insurance coverage'' means individual health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT.—

(A) IN GENERAL.—Except as provided in this paragraph, the individual health insurance issuer offering such coverage does not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y1.

(B) DEPENDENT COVERAGE PERMITTED.—Subparagraph (A) shall not affect the subsequent enrollment of a dependent of an individual who is covered as of such first day.

(2) LIMITATION ON CHANGES IN TERMS OR CONDITIONS.—Subject to paragraph (3) and except as required by law, the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1.

(3) RESTRICTIONS ON PREMIUM INCREASES.—The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

(b) GRACE PERIOD FOR CURRENT EMPLOYMENT-BASED HEALTH PLANS.—

(1) GRACE PERIOD.—

(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 201, including the essential benefit package requirement under section 221.

(B) EXCEPTION FOR LIMITED BENEFITS PLANS.—Subparagraph (A) shall not apply to an employment-based health plan in which the coverage consists only of one or more of the following:

(i) Any coverage described in section 3001(a)(1)(B)(ii)(IV) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

(ii) Excepted benefits (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974), including coverage under a specified disease or illness policy described in paragraph (3)(A) of such section.

(iii) Such other limited benefits as the Commissioner may specify.

In no case shall an employment-based health plan in which the coverage consists only of one or more of the coverage or benefits described in clauses (i) through (iii) be treated as acceptable coverage under this division.

(2) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE.—During the grace period specified in paragraph (1)(A), an employment-based health plan (which may be a high deducible health plan, as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that is described in such paragraph shall be treated as acceptable coverage under this division.

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may only be offered on or after the first day of Y1 as an Exchange-participating health benefits plan.

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Nothing in—

(A) paragraph (1) shall prevent the offering of excepted benefits described in section 2791(c) of the Public Health Service Act so long as such benefits are offered outside the Health Insurance Exchange and are priced separately from health insurance coverage; and

(B) this division shall be construed—

(i) to prevent the offering of a stand-alone plan that offers coverage of excepted benefits described in section 2791(c)(2)(A) of the Public Health Service Act (relating to limited scope dental or vision benefits) for individuals and families from a State-licensed dental and vision carrier; or

(ii) as applying requirements for a qualified health benefits plan to such a stand-alone plan that is offered and priced separately from a qualified health benefits plan.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 211. PROHIBITING PREEXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any of the following: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or any similar factors.

SEC. 212. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS AND PROHIBITING RESCISSIONS.

The requirements of sections 2711 (other than subsections (e) and (f)) and 2712 (other than paragraphs (3), and (6) of subsection (b) and subsection (e)) of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such section 2712(b)(1) shall apply only if, before nonrenewal or discontinuation of coverage, the issuer has provided the enrollee with notice of nonpayment of premiums and there is a grace period during which the enrollee has an opportunity to correct such nonpayment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in section 2712(b)(2) of such Act.

SEC. 213. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for a qualified health benefits plan that is health insurance coverage may not vary except as follows:

(1) LIMITED AGE VARIATION PERMITTED.—By age (within such age categories as the Commissioner shall specify) so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1.

(2) BY AREA.—By premium rating area (as permitted by State insurance regulators or, in the case of Exchange-participating health benefits plans, as specified by the Commissioner in consultation with such regulators).

(3) BY FAMILY ENROLLMENT.—By family enrollment (such as variations within categories and compositions of families) so long as the ratio of the premium for family enrollment (or enrollments) to the premium for individual enrollment is uniform, as specified under State law and consistent with rules of the Commissioner.

(b) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(1) IN GENERAL.—The Commissioner shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a basic plan of the services described in section 222(e)(4)(A).

(2) CONSIDERATIONS.—In making such estimate the Commissioner—

(A) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(B) shall estimate such costs as if such coverage were included for the entire population covered; and

(C) may not estimate such a cost at less than $1 per enrollee, per month.

(c) STUDY AND REPORTS.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large-group-insured and self-insured employer health care markets. Such study shall examine the following:

(A) The types of employers by key characteristics, including size, that purchase insured products versus those that self-insure.

(B) The similarities and differences between typical insured and self-insured health plans.

(C) The financial solvency and capital reserve levels of employers that self-insure by employer size.

(D) The risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent.

(E) The extent to which rating rules are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations the Commissioner deems appropriate to ensure that the law does not provide incentives for small and midsize employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. Not later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations.

SEC. 214. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

(a) NONDISCRIMINATION IN BENEFITS.—A qualified health benefits plan shall comply with standards established by the Commissioner to prohibit discrimination in health benefits or benefit structures for qualifying health benefits plans, building from section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.

(b) PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.—To the extent such provisions are not superceded by or inconsistent with subtitle C, the provisions of section 2705 (other than subsections (a)(1), (a)(2), and (c)) of the Public Health Service Act shall apply to a qualified health benefits plan, regardless of whether it is offered in the individual or group market, in the same manner as such provisions apply to health insurance coverage offered in the large group market.

SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) IN GENERAL.—A qualified health benefits plan that uses a provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such networks in ensuring enrollee access to such items and services and transparency in the cost-sharing differentials among providers participating in the network and policies for accessing out-of-network providers.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a current listing of all providers in its network on its Website and such data shall be available on the Health Insurance Exchange Website as a part of the basic information on that plan. The Commissioner shall also establish an online system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) PROVIDER NETWORK DEFINED.—In this division, the term ''provider network'' means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

(a) IN GENERAL.—A qualified health benefits plan shall make available, at the option of the principal enrollee under the plan, coverage for one or more qualified children (as defined in subsection (b)) of the enrollee.

(b) QUALIFIED CHILD DEFINED.—In this section, the term ''qualified child'' means, with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

(2) is not enrolled in a health benefits plan other than under this section.

(c) PREMIUMS.—Nothing in this section shall be construed as preventing a qualified health benefits plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Commissioner based upon family size under section 213(a)(3).

SEC. 217. CONSISTENCY OF COSTS AND COVERAGE UNDER QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

In the case of health insurance coverage offered under a qualified health benefits plan, if the coverage decreases or the cost-sharing increases, the issuer of the coverage shall notify enrollees of the change at least 90 days before the change takes effect (or such shorter period of time in cases where the change is necessary to ensure the health and safety of enrollees).

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

(a) IN GENERAL.—A qualified health benefits plan shall provide coverage that at least meets the benefit standards adopted under section 224 for the essential benefits package described in section 222 for the plan year involved.

(b) CHOICE OF COVERAGE.—

(1) NON-EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of a qualified health benefits plan that is not an Exchange-participating health benefits plan, such plan may offer such coverage in addition to the essential benefits package as the QHBP offering entity may specify.

(2) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of an Exchange-participating health benefits plan, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium-plus level of benefits, provide additional benefits.

(3) CONTINUATION OF OFFERING OF SEPARATE EXCEPTED BENEFITS COVERAGE.—Nothing in this division shall be construed as affecting the offering outside of the Health Insurance Exchange and under State law of health benefits in the form of excepted benefits (described in section 202(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

(c) CLINICAL APPROPRIATENESS.—Nothing in this Act shall be construed to prohibit a group health plan or health insurance issuer from using medical management practices so long as such management practices are based on valid medical evidence and are relevant to the patient whose medical treatment is under review.

(d) PROVISION OF BENEFITS.—Nothing in this division shall be construed as prohibiting a qualified health benefits plan from subcontracting with stand-alone health insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services.

SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term ''essential benefits package'' means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;

(4) complies with section 215(a) (relating to network adequacy); and

(5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1.

In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

(b) MINIMUM SERVICES TO BE COVERED.—Subject to subsection (d), the items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for—

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention; or

(B) well-baby and well-child care.

(2) ANNUAL LIMITATION.—

(A) ANNUAL LIMITATION.—The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).

(B) APPLICABLE LEVEL.—The applicable level specified in this subparagraph for Y1 is not to exceed $5,000 for an individual and not to exceed $10,000 for a family. Such levels shall be increased (rounded to the nearest $100) for each subsequent year by the annual percentage increase in the enrollment-weighted average of premium increases for basic plans applicable to such year, except that Secretary shall adjust such increase to ensure that the applicable level specified in this subparagraph meets the minimum actuarial value required under paragraph (3).

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) ASSESSMENT AND COUNSELING FOR DOMESTIC VIOLENCE.—The Secretary shall support the need for an assessment and brief counseling for domestic violence as part of a behavioral health assessment or primary care visit and determine the appropriate coverage for such assessment and counseling.

(e) ABORTION COVERAGE PROHIBITED AS PART OF MINIMUM BENEFITS PACKAGE.—

(1) PROHIBITION OF REQUIRED COVERAGE.—The Health Benefits Advisory Committee may not recommend under section 223(b), and the Secretary may not adopt in standards under section 224(b), the services described in paragraph (4)(A) or (4)(B) as part of the essential benefits package and the Commissioner may not require such services for qualified health benefits plans to participate in the Health Insurance Exchange.

(2) VOLUNTARY CHOICE OF COVERAGE BY PLAN.—In the case of a qualified health benefits plan, the plan is not required (or prohibited) under this Act from providing coverage of services described in paragraph (4)(A) or (4)(B) and the QHBP offering entity shall determine whether such coverage is provided.

(3) COVERAGE UNDER PUBLIC HEALTH INSURANCE OPTION.—The public health insurance option shall provide coverage for services described in paragraph (4)(B). Nothing in this Act shall be construed as preventing the public health insurance option from providing for or prohibiting coverage of services described in paragraph (4)(A).

(4) ABORTION SERVICES.—

(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(B) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(f) REPORT REGARDING INCLUSION OF ORAL HEALTH CARE IN ESSENTIAL BENEFITS PACKAGE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package.

SEC. 223. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

(2) CHAIR.—The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee.

(3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) Nine members who are not Federal employees or officers and who are appointed by the President.

(B) Nine members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint.

Such initial appointments shall be made not later than 60 days after the date of the enactment of this Act.

(4) TERMS.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term on the Committee, except that the terms of the initial members shall be adjusted in order to provide for a staggered term of appointment for all such members.

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, patient representatives, employers (including small employers), labor, health insurance issuers, experts in health care financing and delivery, experts in oral health care, experts in racial and ethnic disparities, experts on health care needs and disparities of individuals with disabilities, representatives of relevant governmental agencies, and at least one practicing physician or other health professional and an expert in child and adolescent health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') benefit standards (as defined in paragraph (5)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health disparities.

(2) DEADLINE.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(3) STATE INPUT.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act. The Health Benefits Advisory Committee shall also seek input from the States and consider recommendations on how to ensure quality of health coverage in all States.

(4) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this subsection.

(5) BENEFIT STANDARDS DEFINED.—In this subtitle, the term ''benefit standards'' means standards respecting—

(A) the essential benefits package described in section 222, including categories of covered treatments, items and services within benefit classes, and cost-sharing consistent with subsection (e) of such section; and

(B) the cost-sharing levels for enhanced plans and premium plans (as provided under section 303(c)) consistent with paragraph (5).

(6) LEVELS OF COST-SHARING FOR ENHANCED AND PREMIUM PLANS.—

(A) ENHANCED PLAN.—The level of cost-sharing for enhanced plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 85 percent of the actuarial value of the benefits provided under the reference benefits package described in section 222(c)(3)(B).

(B) PREMIUM PLAN.—The level of cost-sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 222(c)(3)(B).

(c) OPERATIONS.—

(1) PER DIEM PAY.—Each member of the Health Benefits Advisory Committee shall receive travel expenses, including per diem in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code, and shall otherwise serve without additional pay.

(2) MEMBERS NOT TREATED AS FEDERAL EMPLOYEES.—Members of the Health Benefits Advisory Committee shall not be considered employees of the Federal Government solely by reason of any service on the Committee, except such members shall be considered to be within the meaning of section 202(a) of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest.

(3) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the Health Benefits Advisory Committee.

(d) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet Website of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 224. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

(1) REVIEW OF RECOMMENDED STANDARDS.—Not later than 45 days after the date of receipt of benefit standards recommended under section 223 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

(2) DETERMINATION TO ADOPT STANDARDS.—If the Secretary determines—

(A) to propose adoption of benefit standards so recommended as a package, the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of such standards; or

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) CONTINGENCY.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of initial benefit standards by such deadline.

(4) PUBLICATION.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under this subsection.

(b) ADOPTION OF STANDARDS.—

(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall, through the rulemaking process consistent with subsection (a), adopt an initial set of benefit standards.

(2) PERIODIC UPDATING STANDARDS.—Under subsection (a), the Secretary shall provide for the periodic updating of the benefit standards previously adopted under this section.

(3) REQUIREMENT.—The Secretary may not adopt any benefit standards for an essential benefits package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 222 (including subsection (e)) and 223(b)(5).

Subtitle D—Additional Consumer Protections

SEC. 231. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

The Commissioner shall establish uniform marketing standards that all QHBP offering entities shall meet with respect to qualified health benefits plans that are health insurance coverage.

SEC. 232. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

(a) IN GENERAL.—A QHBP offering entity shall provide for timely grievance and appeals mechanisms with respect to qualified health benefits plans that the Commissioner shall establish consistent with this section. The Commissioner shall establish time limits for each of such mechanisms and implement them in a manner that is protective to the needs of patients.

(b) INTERNAL CLAIMS AND APPEALS PROCESS.—Under a qualified health benefits plan

the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update such process in accordance with any standards that the Commissioner may establish.

(c) EXTERNAL REVIEW PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent, and de novo review of denied claims under this division.

(2) REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.—A determination made, with respect to a qualified health benefits plan offered by a QHBP offering entity, under the external review process established under this subsection shall be binding on the plan and the entity.

(d) TIME LIMITS.—The Commissioner shall establish time limits for each of these processes and implement them in a manner that is protective to the patient.

(e) CONSTRUCTION.—Nothing in this section shall be construed as affecting the availability of judicial review under State law for adverse decisions under subsection (b) or (c), subject to section 251.

SEC. 233. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) FOR EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—A QHBP offering entity offering an Exchange-participating health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure to the Commissioner and the public of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner.

(2) EMPLOYMENT-BASED HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Commissioner under paragraph (1).

(3) USE OF PLAIN LANGUAGE.—

(A) IN GENERAL.—The disclosures under paragraphs (1) and (2) shall be provided in plain language.

(B) DEFINITION.—In this paragraph, the term ''plain language'' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

(C) GUIDANCE.—The Commissioner and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(4) INFORMATION ON RIGHTS.—The information disclosed under this subsection shall include information on enrollee and participant rights under this division.

(5) COST-SHARING TRANSPARENCY.—A qualified health benefits plan shall allow individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon request. At a minimum, this information shall be made available to such individual via an Internet Website and other means for individuals without access to the Internet.

(b) CONTRACTING REIMBURSEMENT.—A qualified health benefits plan shall comply with standards established by the Commissioner to ensure transparency to each health care provider relating to reimbursement arrangements between such plan and such provider.

(c) PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.—

(1) IN GENERAL.—If a QHBP offering entity contracts with a pharmacy benefit manager or other entity (in this subsection referred to as a ''PBM'') to manage prescription drug coverage or otherwise control prescription drug costs under a qualified health benefits plan, the PBM shall provide at least annually to the Commissioner and to the QHBP offering entity offering such plan the following information, in a form and manner to be determined by the Commissioner:

(A) Information on the number and total cost of prescriptions under the contract that are filled via mail order and at retail pharmacies.

(B) An estimate of aggregate average payments under the contract, per prescription (weighted by prescription volume), made to mail order and retail pharmacies, and the average amount, per prescription, that the PBM was paid by the plan for prescriptions filled at mail order and retail pharmacists.

(C) An estimate of the aggregate average payment per prescription (weighted by prescription volume) under the contract received from pharmaceutical manufacturers, including all rebates, discounts, prices concessions, or administrative, and other payments from pharmaceutical manufacturers, and a description of the types of payments, and the amount of these payments that were shared with the plan, and a description of the percentage of prescriptions for which the PBM received such payments.

(D) Information on the overall percentage of generic drugs dispensed under the contract at retail and mail order pharmacies, and the percentage of cases in which a generic drug is dispensed when available.

(E) Information on the percentage and number of cases under the contract in which individuals were switched because of PBM policies or at the direct or indirect control of the PBM from a prescribed drug that had a lower cost for the QHBP offering entity to a drug that had a higher cost for the QHBP offering entity, the rationale for these switches, and a description of the PBM policies governing such switches.

(2) CONFIDENTIALITY OF INFORMATION.—Information disclosed by a PBM to the Commissioner or a QHBP offering entity under this subsection is confidential and shall not be disclosed by the Commissioner or the QHBP offering entity in a form which discloses the identity of a specific PBM or prices charged by such PBM or a specific retailer, manufacturer, or wholesaler, except only by the Commissioner—

(A) to permit State or Federal law enforcement authorities to use the information provided for program compliance purposes and for the purpose of combating waste, fraud, and abuse;

(B) to permit the Comptroller General, the Medicare Payment Advisory Commission, or the Secretary of Health and Human Services to review the information provided; and

(C) to permit the Director of the Congressional Budget Office to review the information provided.

(3) ANNUAL PUBLIC REPORT.—On an annual basis, the Commissioner shall prepare a public report providing industrywide aggregate or average information to be used in assessing the overall impact of PBMs on prescription drug prices and spending. Such report shall not disclose the identity of a specific PBM, or prices charged by such PBM, or a specific retailer, manufacturer, or wholesaler, or any other confidential or trade secret information.

(4) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a PBM that fails to provide information required under subsection (a) or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under such section that fails to provide information under subsection (b)(3)(A) of such section or knowingly provides false information under such section, respectively.

SEC. 234. APPLICATION TO QUALIFIED HEALTH BENEFITS PLANS NOT OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

The requirements of the previous provisions of this subtitle shall apply to qualified health benefits plans that are not being offered through the Health Insurance Exchange only to the extent specified by the Commissioner.

SEC. 235. TIMELY PAYMENT OF CLAIMS.

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to a qualified health benefits plan it offers in the same manner as a Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 236. STANDARDIZED RULES FOR COORDINATION AND SUBROGATION OF BENEFITS.

The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases of qualified health benefits plans involving individuals and multiple plan coverage.

SEC. 237. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

A QHBP offering entity is required to comply with administrative simplification provisions under part C of title XI of the Social Security Act with respect to qualified health benefits plans it offers.

SEC. 238. STATE PROHIBITIONS ON DISCRIMINATION AGAINST HEALTH CARE PROVIDERS.

This Act (and the amendments made by this Act) shall not be construed as superseding laws, as they now or hereinafter exist, of any State or jurisdiction designed to prohibit a qualified health benefits plan from discriminating with respect to participation, reimbursement, covered services, indemnification, or related requirements under such plan against a health care provider that is acting within the scope of that provider's license or certification under applicable State law.

SEC. 239. PROTECTION OF PHYSICIAN PRESCRIBER INFORMATION.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on the use of physician prescriber information in sales and marketing practices of pharmaceutical manufacturers.

(b) REPORT.—Based on the study conducted under subsection (a), the Secretary shall submit to Congress a report on actions needed to be taken by the Congress or the Secretary to protect providers from biased marketing and sales practices.

SEC. 240. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.

(a) IN GENERAL.—The QHBP offering entity —

(1) shall provide for the dissemination of information related to end-of-life planning

to individuals seeking enrollment in Exchange-participating health benefits plans offered through the Exchange;

(2) shall present such individuals with—

(A) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

(3) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under paragraph (2) shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(b) CONSTRUCTION.— Nothing in this section shall be construed—

(1) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(2) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health benefits plan; or

(3) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(c) ADVANCED DIRECTIVE DEFINED.—In this section, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

(d) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to apply to or affect any option to—

(A) withhold or withdraw of medical treatment or medical care;

(B) withhold or withdraw of nutrition or hydration; and

(C) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(3) NO PREEMPTION OF STATE LAW.—Nothing in this section shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

Subtitle E—Governance

SEC. 241. HEALTH CHOICES ADMINISTRATION; HEALTH CHOICES COMMISSIONER.

(a) IN GENERAL.—There is hereby established, as an independent agency in the executive branch of the Government, a Health Choices Administration (in this division referred to as the ''Administration'').

(b) COMMISSIONER.—

(1) IN GENERAL.—The Administration shall be headed by a Health Choices Commissioner (in this division referred to as the ''Commissioner'') who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) COMPENSATION; ETC.—The provisions of paragraphs (2), (5), and (7) of subsection (a) (relating to compensation, terms, general powers, rulemaking, and delegation) of section 702 of the Social Security Act (42 U.S.C. 902) shall apply to the Commissioner and the Administration in the same manner as such provisions apply to the Commissioner of Social Security and the Social Security Administration.

(c) INSPECTOR GENERAL.—For provision establishing an Office of the Inspector General for the Health Choices Administration, see section 1647.

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) DUTIES.—The Commissioner is responsible for carrying out the following functions under this division:

(1) QUALIFIED PLAN STANDARDS.—The establishment of qualified health benefits plan standards under this title, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH INSURANCE EXCHANGE.—The establishment and operation of a Health Insurance Exchange under subtitle A of title III.

(3) INDIVIDUAL AFFORDABILITY CREDITS.—The administration of individual affordability credits under subtitle C of title III, including determination of eligibility for such credits.

(4) ADDITIONAL FUNCTIONS.—Such additional functions as may be specified in this division.

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(A) IN GENERAL.—The Commissioner shall, in coordination with States, conduct audits of qualified health benefits plan compliance with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected noncompliance.

(B) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities.

(c) DATA COLLECTION.—The Commissioner shall collect data for purposes of carrying out the Commissioner's duties, including for purposes of promoting quality and value, protecting consumers, and addressing disparities in health and health care and may share such data with the Secretary of Health and Human Services.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—In the case that the Commissioner determines that a QHBP offering entity violates a requirement of this title, the Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph, with respect to a qualified health benefits plan offered by a QHBP offering entity, are—

(A) civil money penalties of not more than the amount that would be applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act;

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the entity under the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the requirements of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 308 and 341(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 243. CONSULTATION AND COORDINATION.

(a) CONSULTATION.—In carrying out the Commissioner's duties under this division, the Commissioner, as appropriate, shall consult at least with the following:

(1) State attorneys general and State insurance regulators, including concerning the standards for health insurance coverage that is a qualified health benefits plan under this title and enforcement of such standards.

(2) The National Association of Insurance Commissioners, including for purposes of using model guidelines established by such association for purposes of subtitles B and D.

(3) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of title III and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(4) The Federal Trade Commission, specifically concerning the development and issuance of guidance, rules, or standards regarding fair marketing practices under section 231 or otherwise, or any consumer disclosure requirements under section 233 or otherwise.

(5) Other appropriate Federal agencies.

(6) Indian tribes and tribal organizations.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner, in coordination with such entities, shall seek to achieve uniform standards that adequately protect consumers in a manner that does not unreasonably affect employers and insurers.

SEC. 244. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Qualified Health Benefits Plan Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals.

(b) DUTIES.—The Qualified Health Benefits Plan Ombudsman shall, in a linguistically appropriate manner—

(1) receive complaints, grievances, and requests for information submitted by individuals through means such as the mail, by telephone, electronically, and in person;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant information needed to seek an appeal of a decision or determination;

(B) assistance to such individuals in choosing a qualified health benefits plan in which to enroll;

(C) assistance to such individuals with any problems arising from disenrollment from such a plan; and

(D) assistance to such individuals in presenting information under subtitle C (relating to affordability credits); and

(3) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 251. RELATION TO OTHER REQUIREMENTS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan), and in the case of employment-based health plans, the requirements of this title do not supercede any requirements applicable under titles XXII and XXVII of the Public Health Service Act, parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner.

(2) CONSTRUCTION.—Nothing in paragraphs (1) or (2) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange—

(A) the requirements of this title do not supercede any requirements (including requirements relating to genetic information nondiscrimination and mental health parity) applicable under title XXVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

(B) individual rights and remedies under State laws shall apply.

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws to health insurance issuers generally with respect to any requirement referred to in paragraph (1)(A). The previous sentence shall not be construed as providing for the applicability of rights or remedies under State laws with respect to requirements applicable to employers or other plan sponsors in connection with arrangements which are treated as group health plans under section 802(a)(1) of the Employee Retirement Income Security Act of 1974.

SEC. 252. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services.

(b) IMPLEMENTATION.—To implement the requirement set forth in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including insurance coverage and public health activities) covered by this Act are provided (whether directly or through contractual, licensing, or other arrangements) without regard to personal characteristics extraneous to the provision of high quality health care or related services.

SEC. 253. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or any person acting pursuant to a request of the employee)—

(1) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of any provision of this Act or any order, rule, or regulation promulgated under this Act;

(2) testified or is about to testify in a proceeding concerning such violation;

(3) assisted or participated or is about to assist or participate in such a proceeding; or

(4) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act.

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of subsection (a) may bring an action governed by the rules, procedures, legal burdens of proof, and remedies set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(c) EMPLOYER DEFINED.—As used in this section, the term ''employer'' means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

(d) RULE OF CONSTRUCTION.—The rule of construction set forth in section 20109(h) of title 49, United States Code, shall also apply to this section.

SEC. 254. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

Nothing in this division shall be construed to alter or supersede any statutory or other obligation to engage in collective bargaining over the terms or conditions of employment related to health care. Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this division shall not be treated as a termination of such collective bargaining agreement.

SEC. 255. SEVERABILITY.

If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, the remainder of the provisions of this Act and the application of the provision to any other person or circumstance shall not be affected.

SEC. 256. TREATMENT OF HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)), and such exemption shall also apply with respect to the provisions of this division; and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate officials of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 257. ACTIONS BY STATE ATTORNEYS GENERAL.

Any State attorney general may bring a civil action in the name of such State as *parens patriae* on behalf of natural persons residing in such State, in any district court of the United States or State court having jurisdiction of the defendant to secure monetary or equitable relief for violation of any provisions of this title or regulations issued thereunder. Nothing in this section shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

SEC. 258. APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.

(a) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(b) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(A) conscience protection;

(B) willingness or refusal to provide abortion; and

(C) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(c) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this section shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

SEC. 259. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

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

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

(2) require any health plan created or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination,

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

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

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

SEC. 260. AUTHORITY OF FEDERAL TRADE COMMISSION.

Section 6 of the Federal Trade Commission Act (15 U.S.C. 46) is amended by striking ''and prepare reports'' and all that follows and inserting the following: ''and prepare reports, and to share information under clauses (f) and (k), relating to insurance. Notwithstanding section 4, the Commission's authority shall include the authority to conduct studies and prepare reports, and to share information under clauses (f) and (k), relating to insurance, without regard to whether the subject of such studies, reports, or information is for-profit or not-for-profit entity.''.

SEC. 261. CONSTRUCTION REGARDING STANDARD OF CARE.

(a) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under a provision described in subsection (b) shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7)).

(b) PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) Section 324 (relating to modernized payment initiatives and delivery system reform under the public health option).

(2) The amendments made by section 1151 (relating to reducing potentially preventable hospital readmissions).

(3) The amendments made by section 1751 (relating to health care acquired conditions).

(4) Section 3131 of the Public Health Service Act (relating to the Task Force on Clinical Preventive Services), added by section 2301.

(5) Part D of title IX of the Public Health Service Act (relating to implementation of best practices in the delivery of health care), added by section 2401.

(c) SAVINGS CLAUSE FOR STATE MEDICAL MAL-PRACTICE LAWS.—Nothing in this Act or the amendments made by this Act shall be construed to modify or impair State law governing legal standards or procedures used in medical malpractice cases, including the authority of a State to make or implement such laws.

SEC. 262. RESTORING APPLICATION OF ANTITRUST LAWS TO HEALTH SECTOR INSURERS.

(a) AMENDMENT TO MCCARRAN-FERGUSON ACT.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

''(c)(1) Except as provided in paragraph (2), nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance or the business of medical malpractice insurance.

''(2) Paragraph (1) shall not apply to—

''(A) collecting, compiling, classifying, or disseminating historical loss data;

''(B) determining a loss development factor applicable to historical loss data; or

''(C) performing actuarial services if doing so does not involve a restraint of trade.

''(3) For purposes of this subsection—

''(A) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition;

''(B) the term 'historical loss data' means information respecting claims paid, or reserves held for claims reported, by any person engaged in the business of insurance; and

''(C) the term 'loss development factor' means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid.''.

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance, and with respect to the business of medical malpractice insurance, without regard to whether such business is carried on for profit, notwithstanding the definition of ''Corporation'' contained in section 4 of the Federal Trade Commission Act.

(c) RELATED PRESERVATION OF ANTITRUST LAWS.—Except as provided in subsections (a) and (b), nothing in this Act, or in the amendments made by this Act, shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For purposes of the preceding sentence, the term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

SEC. 263. STUDY AND REPORT ON METHODS TO INCREASE EHR USE BY SMALL HEALTH CARE PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of potential methods to increase the use of qualified electronic health records (as defined in section 3000(13) of the Public Health Service Act) by small health care providers. Such study shall consider at least the following methods:

(1) Providing for higher rates of reimbursement or other incentives for such health care providers to use electronic health records (taking into consideration initiatives by private health insurance companies and incentives provided under Medicare under title XVIII of the Social Security Act, Medicaid under title XIX of such Act, and other programs).

(2) Promoting low-cost electronic health record software packages that are available for use by such health care providers, including software packages that are available to health care providers through the Veterans Administration and other sources.

(3) Training and education of such health care providers on the use of electronic health records.

(4) Providing assistance to such health care providers on the implementation of electronic health records.

(b) REPORT.—Not later than December 31, 2013, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subsection (a), including recommendations for legislation or administrative action to increase the use of electronic health records by small health care providers that include the use of both public and private funding sources.

SEC. 264. PREFORMANCE ASSESSMENT AND ACCOUNTABILITY: APPLICATION OF GPRA.

(a) APPLICATION OF GPRA.—Section 306 of title 5, United States Code, and sections 1115, 1116, 1117, and 9703 of title 31 of such Code (originally enacted by the Government Performance and Results Act of 1993, Public Law 103–62) apply to the executive agencies established by this Act, including the Health Choices Administration. Under such section 306, each such executive agency is required to provide for a strategic plan every 3 years.

(b) IMPROVING CONSUMER SERVICE AND STREAMLINING PROCEDURES.—Every 3 years each such executive agency shall—

(1)(A) assess the quality of customer service provided, (B) develop a strategy for improving such service, and (C) establish standards for high-quality customer service; and

(2)(A) identify redundant rules, regulations, and procedures, and (B) develop and implement a plan for eliminating or streamlining such redundancies.

TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 301. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE; OUTLINE OF DUTIES; DEFINITIONS.

(a) ESTABLISHMENT.—There is established within the Health Choices Administration and under the direction of the Commissioner a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 243(b), the Commissioner shall—

(1) under section 304 establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under section 303, and including with respect to oversight and enforcement;

(2) under section 305 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 302; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 306 and consumer protections under subtitle D of title II.

SEC. 302. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

(a) ACCESS TO COVERAGE.—In accordance with this section, all individuals are eligible

to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Health Insurance Exchange unless such individuals are enrolled in another qualified health benefits plan or certain other acceptable coverage.

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term ''Exchange-eligible individual'' means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term ''Exchange-eligible employer'' means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms ''employer'', ''employee'', ''full-time employee'', and ''part-time employee'' have the meanings given such terms by the Commissioner for purposes of this division.

(c) TRANSITION.—Individuals and employers shall only be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following transition schedule:

(1) FIRST YEAR.—In Y1 (as defined in section 100(c))—

(A) individuals described in subsection (d)(1), including individuals described in subsection (d)(3); and

(B) smallest employers described in subsection (e)(1).

(2) SECOND YEAR.—In Y2—

(A) individuals and employers described in paragraph (1); and

(B) smaller employers described in subsection (e)(2).

(3) THIRD AND SUBSEQUENT YEARS.—In Y3—

(A) individuals and employers described in paragraph (2);

(B) small employers described in subsection (e)(3); and

(C) larger employers as permitted by the Commissioner under subsection (e)(4).

(d) INDIVIDUALS.—

(1) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who—

(A) is not enrolled in coverage described in subparagraph (C) or (D) of paragraph (2); and

(B) is not enrolled in coverage as a full-time employee (or as a dependent of such an employee) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 412.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirements of section 412, such individual shall be deemed a full-time employee described in such subparagraph.

(2) ACCEPTABLE COVERAGE.—For purposes of this division, the term ''acceptable coverage'' means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202) or under a current group health plan (described in subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (z), or (aa), or (hh) of section 1902 of such Act.

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code.

(G) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this paragraph.

The Commissioner shall make determinations under this paragraph in coordination with the Secretary of the Treasury.

(3) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under this subsection (including as an employee or dependent of an employee of an Exchange-eligible employer) and enrolls under an Exchange-participating health benefits plan through the Health Insurance Exchange, the individual shall continue to be treated as an Exchange-eligible individual until the individual is no longer enrolled with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to an individual once the individual becomes eligible for coverage—

(I) under part A of the Medicare program;

(II) under the Medicaid program as a Medicaid-eligible individual, except as permitted under clause (ii); or

(III) in such other circumstances as the Commissioner may provide.

(ii) TRANSITION PERIOD.—In the case described in clause (i)(II), the Commissioner shall permit the individual to continue treatment under subparagraph (A) until such limited time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual's access to health care.

(4) TRANSITION FOR CHIP ELIGIBLES.—An individual who is eligible for child health assistance under title XXI of the Social Security Act for a period during Y1 shall not be an Exchange-eligible individual during such period.

(e) EMPLOYERS.—

(1) SMALLEST EMPLOYER.—Subject to paragraph (5), smallest employers described in this paragraph are employers with 25 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (5), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and have 50 or fewer employees.

(3) SMALL EMPLOYERS.—Subject to paragraph (5), small employers described in this paragraph are employers that are not described in paragraph (1) or (2) and have 100 or fewer employees.

(4) LARGER EMPLOYERS.—

(A) IN GENERAL.—Beginning with Y3, the Commissioner may permit employers not described in paragraph (1), (2), or (3) to be Exchange-eligible employers.

(B) PHASE-IN.—In applying subparagraph (A), the Commissioner may phase-in the application of such subparagraph based on the number of full-time employees of an employer and such other considerations as the Commissioner deems appropriate.

(5) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement of section 411(a) through paragraph (1) of such section by offering a group health plan and not through offering an Exchange-participating health benefits plan.

(6) EMPLOYER PARTICIPATION AND CONTRIBUTIONS.—

(A) SATISFACTION OF EMPLOYER RESPONSIBILITY.—For any year in which an employer is an Exchange-eligible employer, such employer may meet the requirements of section 412 with respect to employees of such employer by offering such employees the option of enrolling with Exchange-participating health benefits plans through the Health Insurance Exchange consistent with the provisions of subtitle B of title IV.

(B) EMPLOYEE CHOICE.—Any employee offered Exchange-participating health benefits plans by the employer of such employee under subparagraph (A) may choose coverage under any such plan. That choice includes, with respect to family coverage, coverage of the dependents of such employee.

(7) AFFILIATED GROUPS.—Any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated, for purposes of this subtitle, as a single employer.

(8) TREATMENT OF MULTI-EMPLOYER PLANS.—The plan sponsor of a group health plan (as defined in section 773(a) of the Employee Retirement Income Security Act of 1974) that is a multi-employer plan (as defined in section 3(37) of such Act) may obtain health insurance coverage with respect to participants in the plan through the Exchange to the same extent that an employer not described in paragraph (1) or (2) is permitted by the Commissioner to obtain health insurance coverage through the Exchange as an Exchange-eligible employer.

(9) OTHER COUNTING RULES.—The Commissioner shall establish rules relating to how employees are counted for purposes of carrying out this subsection.

(f) SPECIAL SITUATION AUTHORITY.—The Commissioner shall have the authority to establish such rules as may be necessary to deal with special situations with regard to uninsured individuals and employers participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

(g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The Commissioner shall provide for periodic surveys of Exchange-eligible individuals and employers concerning satisfaction of such individuals and employers with the Health Insurance Exchange and Exchange-participating health benefits plans.

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange-eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

(2) ITEMS INCLUDED IN STUDY.—Such study also shall examine—

(A) the terms, conditions, and affordability of group health coverage offered by employers and QHBP offering entities outside of the

Exchange compared to Exchange-participating health benefits plans; and

(B) the affordability-test standard for access of certain employed individuals to coverage in the Health Insurance Exchange.

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress a report on the study conducted under this subsection and shall include in such report recommendations regarding changes in standards for Exchange eligibility for individuals and employers.

SEC. 303. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title II and this section.

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The Commissioner may not enter into a contract with a QHBP offering entity under section 304(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

(1) REQUIRED OFFERING OF BASIC PLAN.—The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF ENHANCED PLAN.—If and only if the entity offers a basic plan for such service area, the entity may offer one enhanced plan for such area.

(3) OPTIONAL OFFERING OF PREMIUM PLAN.—If and only if the entity offers an enhanced plan for such service area, the entity may offer one premium plan for such area.

(4) OPTIONAL OFFERING OF PREMIUM-PLUS PLANS.—If and only if the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area.

All such plans may be offered under a single contract with the Commissioner.

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

(1) IN GENERAL.—The Commissioner shall establish the following standards consistent with this subsection and title II:

(A) BASIC, ENHANCED, AND PREMIUM PLANS.—Standards for 3 levels of Exchange-participating health benefits plans: basic, enhanced, and premium (in this division referred to as a ''basic plan'', ''enhanced plan'', and ''premium plan'', respectively).

(B) PREMIUM-PLUS PLAN BENEFITS.—Standards for additional benefits that may be offered, consistent with this subsection and subtitle C of title II, under a premium plan (such a plan with additional benefits referred to in this division as a ''premium-plus plan'').

(2) BASIC PLAN.—

(A) IN GENERAL.—A basic plan shall offer the essential benefits package required under title II for a qualified health benefits plan with an actuarial value of 70 percent of the full actuarial value of the benefits provided under the reference benefits package.

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS.—In the case of an affordable credit eligible individual (as defined in section 342(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are modified to provide for the reduced cost-sharing for the income tier applicable to the individual under section 324(c).

(3) ENHANCED PLAN.—An enhanced plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(A).

(4) PREMIUM PLAN.—A premium plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(B).

(5) PREMIUM-PLUS PLAN.—A premium-plus plan is a premium plan that also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits shall be separately specified.

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 222. Nothing in this subtitle shall be construed as prohibiting tiering in cost-sharing, including through preferred and participating providers and prescription drugs. In applying this paragraph, a health benefits plan may increase the cost-sharing by 10 percent within each category or tier, as applicable, and may decrease or eliminate cost-sharing in any category or tier as compared to the essential benefits package.

(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.

(e) RULES REGARDING COVERAGE OF AND AFFORDABILITY CREDITS FOR SPECIFIED SERVICES.—

(1) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH THE HEALTH INSURANCE EXCHANGE.—The Commissioner shall assure that, of the Exchange participating health benefits plans offered in each premium rating area of the Health Insurance Exchange—

(A) there is at least one such plan that provides coverage of services described in subparagraphs (A) and (B) of section 222(e)(4); and

(B) there is at least one such plan that does not provide coverage of services described in section 222(e)(4)(A) which plan may also be one that does not provide coverage of services described in section 222(e)(4)(B).

(2) SEGREGATION OF FUNDS.—If a qualified health benefits plan provides coverage of services described in section 222(e)(4)(A), the plan shall provide assurances satisfactory to the Commissioner that—

(A) any affordability credits provided under subtitle C of title II are not used for purposes of paying for such services; and

(B) only premium amounts attributable to the actuarial value described in section 213(b) are used for such purpose.

SEC. 304. CONTRACTS FOR THE OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.

(a) CONTRACTING DUTIES.—In carrying out section 301(b)(1) and consistent with this subtitle:

(1) OFFERING ENTITY AND PLAN STANDARDS.—The Commissioner shall—

(A) establish standards necessary to implement the requirements of this title and title II for—

(i) QHBP offering entities for the offering of an Exchange-participating health benefits plan; and

(ii) Exchange-participating health benefits plans; and

(B) certify QHBP offering entities and qualified health benefits plans as meeting such standards and requirements of this title and title II for purposes of this subtitle.

(2) SOLICITING AND NEGOTIATING BIDS; CONTRACTS.—

(A) BID SOLICITATION.—The Commissioner shall solicit bids from QHBP offering entities for the offering of Exchange-participating health benefits plans. Such bids shall include justification for proposed premiums.

(B) BID REVIEW AND NEGOTIATION.—The Commissioner shall, based upon a review of such bids including the premiums and their affordability, negotiate with such entities for the offering of such plans.

(C) DENIAL OF EXCESSIVE PREMIUMS.—The Commissioner shall deny excessive premiums and premium increases.

(D) CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this title) negotiated between the Commissioner and such entities.

(3) FEDERAL ACQUISITION REGULATION.—In carrying out this subtitle, the Commissioner may waive such provisions of the Federal Acquisition Regulation that the Commissioner determines to be inconsistent with the furtherance of this subtitle, other than provisions relating to confidentiality of information. Competitive procedures shall be used in awarding contracts under this subtitle to the extent that such procedures are consistent with this subtitle.

(b) STANDARDS FOR QHBP OFFERING ENTITIES TO OFFER EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—The standards established under subsection (a)(1)(A) shall require that, in order for a QHBP offering entity to offer an Exchange-participating health benefits plan, the entity must meet the following requirements:

(1) LICENSED.—The entity shall be licensed to offer health insurance coverage under State law for each State in which it is offering such coverage.

(2) DATA REPORTING.—The entity shall provide for the reporting of such information as the Commissioner may specify, including information necessary to administer the risk pooling mechanism described in section 306(b) and information to address disparities in health and health care.

(3) AFFORDABILITY.—The entity shall provide for affordable premiums.

(4) IMPLEMENTING AFFORDABILITY CREDITS.—The entity shall provide for implementation of the affordability credits provided for enrollees under subtitle C, including the reduction in cost-sharing under section 344(c).

(5) ENROLLMENT.—The entity shall accept all enrollments under this subtitle, subject to such exceptions (such as capacity limitations) in accordance with the requirements under title II for a qualified health benefits plan. The entity shall notify the Commissioner if the entity projects or anticipates reaching such a capacity limitation that would result in a limitation in enrollment.

(6) RISK POOLING PARTICIPATION.—The entity shall participate in such risk pooling mechanism as the Commissioner establishes under section 306(b).

(7) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall include within the plan network those essential community providers, where available, that serve predominantly low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (as amended by section 221 of Public Law 111–8). The Commissioner shall

specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act. This paragraph shall not be construed to require a basic plan to contract with a provider if such provider refuses to accept the generally applicable payment rates of such plan.

(8) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS.—The entity shall provide for culturally and linguistically appropriate communication and health services.

(9) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS.—

(A) CHOICE OF PROVIDERS.—The entity shall—

(i) demonstrate to the satisfaction of the Commissioner that it has contracted with a sufficient number of Indian health care providers to ensure timely access to covered services furnished by such providers to individual Indians through the entity's Exchange-participating health benefits plan; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered services provided to those enrollees who are eligible to receive services from such providers at a rate that is not less than the level and amount of payment which the entity would make for the services of a participating provider which is not an Indian health care provider.

(B) SPECIAL RULE RELATING TO INDIAN HEALTH CARE PROVIDERS.—Provision of services by an Indian health care provider exclusively to Indians and their dependents shall not constitute discrimination under this Act.

(10) PROGRAM INTEGRITY STANDARDS.—The entity shall establish and operate a program to protect and promote the integrity of Exchange-participating health benefits plans it offers, in accordance with standards and functions established by the Commissioner.

(11) ADDITIONAL REQUIREMENTS.—The entity shall comply with other applicable requirements of this title, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums and related grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

(c) CONTRACTS.—

(1) BID APPLICATION.—To be eligible to enter into a contract under this section, a QHBP offering entity shall submit to the Commissioner a bid at such time, in such manner, and containing such information as the Commissioner may require.

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(3) ENFORCEMENT OF NETWORK ADEQUACY.—In the case of a health benefits plan of a QHBP offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 215; and

(B) an individual enrolled in such plan receives an item or service from a provider that is not within such network;

then any cost-sharing for such item or service shall be equal to the amount of such cost-sharing that would be imposed if such item or service was furnished by a provider within such network.

(4) OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES.—The Commissioner shall establish processes, in coordination with State insurance regulators, to oversee, monitor, and enforce applicable requirements of this title with respect to QHBP offering entities offering Exchange-participating health benefits plans, including the marketing of such plans. Such processes shall include the following:

(A) GRIEVANCE AND COMPLAINT MECHANISMS.—The Commissioner shall establish, in coordination with State insurance regulators, a process under which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 242(d).

(C) TERMINATION.—

(i) IN GENERAL.—The Commissioner may terminate a contract with a QHBP offering entity under this section for the offering of an Exchange-participating health benefits plan if such entity fails to comply with the applicable requirements of this title. Any determination by the Commissioner to terminate a contract shall be made in accordance with formal investigation and compliance procedures established by the Commissioner under which—

(I) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner's determination; and

(II) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(ii) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Clause (i) shall not apply if the Commissioner determines that a delay in termination, resulting from compliance with the procedures specified in such clause prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under the qualified health benefits plan of the QHBP offering entity.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of title II with respect to an entity for a violation of such a requirement.

(5) SPECIAL RULE RELATED TO COST-SHARING AND INDIAN HEALTH CARE PROVIDERS.—The contract under this section with a QHBP offering entity for a health benefits plan shall provide that if an individual who is an Indian is enrolled in such a plan and such individual receives a covered item or service from an Indian health care provider (regardless of whether such provider is in the plan's provider network), the cost-sharing for such item or service shall be equal to the amount of cost-sharing that would be imposed if such item or service—

(A) had been furnished by another provider in the plan's provider network; or

(B) in the case that the plan has no such network, was furnished by a non-Indian provider.

(6) NATIONAL PLAN.—Nothing in this section shall be construed as preventing the Commissioner from entering into a contract under this subsection with a QHBP offering entity for the offering of a health benefits plan with the same benefits in every State so long as such entity is licensed to offer such plan in each State and the benefits meet the applicable requirements in each such State.

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

SEC. 305. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(1) OUTREACH.—The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (3) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments.

(2) ELIGIBILITY.—The Commissioner shall make timely determinations of whether individuals and employers are Exchange-eligible individuals and employers (as defined in section 302).

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

(A) OPEN ENROLLMENT PERIOD.—The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll in an Exchange-participating health benefits plan for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be during September through November of each year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be less than 30 days.

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

(ii) experiences a change in marital or other dependent status;

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(C) ENROLLMENT INFORMATION.—The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(3) AUTOMATIC ENROLLMENT FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals

who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) SUBSIDIZED INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an Exchange-eligible individual who is either of the following:

(i) AFFORDABILITY CREDIT ELIGIBLE INDIVIDUALS.—The individual—

(I) has applied for, and been determined eligible for, affordability credits under subtitle C;

(II) has not opted out from receiving such affordability credit; and

(III) does not otherwise enroll in another Exchange-participating health benefits plan.

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual who is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) and who does not otherwise enroll in another Exchange-participating health benefits plan.

(4) DIRECT PAYMENT OF PREMIUMS TO PLANS.—Under the enrollment process, individuals enrolled in an Exchange-participating health benefits plan shall pay such plans directly, and not through the Commissioner or the Health Insurance Exchange.

(c) COVERAGE INFORMATION AND ASSISTANCE.—

(1) COVERAGE INFORMATION.—The Commissioner shall provide for the broad dissemination of information on Exchange-participating health benefits plans offered under this title. Such information shall be provided in a comparative manner, and shall include information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction.

(2) CONSUMER ASSISTANCE WITH CHOICE.—To provide assistance to Exchange-eligible individuals and employers, the Commissioner shall—

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet Web site through which individuals may obtain information on coverage under Exchange-participating health benefits plans and file complaints;

(B) develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities;

(C) assist Exchange-eligible individuals in selecting Exchange-participating health benefits plans and obtaining benefits through such plans; and

(D) ensure that the Internet Web site described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 233(a)(2)).

(3) USE OF OTHER ENTITIES.—In carrying out this subsection, the Commissioner may work with other appropriate entities to facilitate the dissemination of information under this subsection and to provide assistance as described in paragraph (2).

(d) COVERAGE FOR CERTAIN NEWBORNS UNDER MEDICAID.—

(1) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, for the period of time beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

(A) to be a Medicaid eligible individual for purposes of this division and Medicaid; and

(B) to be automatically enrolled in Medicaid as a traditional Medicaid eligible individual (as defined in section 1943(c) of the Social Security Act).

(2) EXTENDED TREATMENT AS MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in paragraph (1) who at the end of the period referred to in such paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(b)(1) of the Social Security Act) to be a Medicaid eligible individual described in section 1902(l)(1)(B) of such Act.

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) MEDICAID ENROLLMENT OBLIGATION.—An individual may apply, in the manner described in section 341(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding under paragraph (2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(2) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State's Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State Medicaid plan.

(f) EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

(g) ROLE FOR ENROLLMENT AGENTS AND BROKERS.—Nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefits plans including the public health insurance option.

(h) ASSISTANCE FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—The Commissioner, in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers counseling and technical assistance with respect to the provision of health insurance to employees of such employers through the Health Insurance Exchange.

(2) DUTIES.—The program established under paragraph (1) shall include the following services:

(A) Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options.

(B) Distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health Insurance Exchange, including standardized comparative information on the health plans available under the Health Insurance Exchange.

(C) Distribution of information to small employers with respect to available affordability credits or other financial assistance.

(D) Referrals to appropriate entities of complaints and questions relating to the Health Insurance Exchange.

(E) Enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange.

(F) Responses to questions relating to the Health Insurance Exchange and the program established under paragraph (1).

(3) AUTHORITY TO PROVIDE SERVICES DIRECTLY OR BY CONTRACT.—The Commissioner may provide services under paragraph (2) directly or by contract with nonprofit entities that the Commissioner determines capable of carrying out such services.

(4) SMALL EMPLOYER DEFINED.—In this subsection, the term ''small employer'' means an employer with less than 100 employees.

(i) PARTICIPATION OF SMALL EMPLOYER BENEFIT ARRANGEMENTS.—

(1) IN GENERAL.—The Commissioner may enter into contracts with small employer benefit arrangements to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an arrangement under Exchange participating health benefits plans.

(2) SMALL EMPLOYER BENEFIT ARRANGEMENT DEFINED.—In this subsection, the term ''small employer benefit arrangement'' means a not-for-profit agricultural or other cooperative that—

(A) consists solely of its members and is operated for the primary purpose of providing affordable employee benefits to its members;

(B) only has as members small employers in the same industry or line of business;

(C) has no member that has more than a 5 percent voting interest in the cooperative; and

(D) is governed by a board of directors elected by its members.

SEC. 306. OTHER FUNCTIONS.

(a) COORDINATION OF AFFORDABILITY CREDITS.—The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits under subtitle C to QHBP offering entities offering Exchange-participating health benefits plans.

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employees enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities. For purposes of the previous sentence, the Commissioner may utilize data regarding enrollee demographics, inpatient and outpatient diagnoses (in a similar manner as such data are used under parts C and D of title XVIII of the Social Security Act), and such other information as the Secretary determines may be necessary, such as the actual medical costs of enrollees during the previous year.

SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE TRUST FUND.—There is created within the Treasury of the United States a trust fund to be known as the ''Health Insurance Exchange Trust Fund'' (in this section referred to as the ''Trust Fund''), consisting of such amounts as may be appropriated or credited to the Trust Fund under this section or any other provision of law.

(b) PAYMENTS FROM TRUST FUND.—The Commissioner shall pay from time to time from the Trust Fund such amounts as the Commissioner determines are necessary to make payments to operate the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(c) TRANSFERS TO TRUST FUND.—

(1) DEDICATED PAYMENTS.—There are hereby appropriated to the Trust Fund amounts equivalent to the following:

(A) TAXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals).

(B) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under sections 3111(c) and 3221(c) of the Internal Revenue Code of 1986 (relating to employers electing to not provide health benefits).

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b) plus such amounts as are necessary reduced by the amounts deposited under paragraph (1).

(d) APPLICATION OF CERTAIN RULES.—Rules similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

SEC. 308. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange,

then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange if it meets the requirements for approval under subsection (b).

(b) REQUIREMENTS FOR APPROVAL.—

(1) IN GENERAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(A) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(i) negotiating and contracting with QHBP offering entities for the offering of Exchange-participating health benefits plans, which satisfy the standards and requirements of this title and title II;

(ii) enrolling Exchange-eligible individuals and employers in such State in such plans;

(iii) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(iv) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Government which does exceed the cost to the Federal Government if this section did not apply; and

(v) enforcement activities consistent with Federal requirements.

(B) There is no more than one Health Insurance Exchange operating with respect to any one State.

(C) The State provides assurances satisfactory to the Commissioner that approval of such an Exchange will not result in any net increase in expenditures to the Federal Government.

(D) The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Commissioner that it will vigorously enforce violations of applicable requirements.

(E) Such other requirements as the Commissioner may specify.

(2) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(A) IN GENERAL.—In the case of a State operating an Exchange prior to January 1, 2010, that seeks to operate the State-based Health Insurance Exchange under this section, the Commissioner shall presume that such Exchange meets the standards under this section unless the Commissioner determines, after completion of the process established under subparagraph (B), that the Exchange does not comply with such standards.

(B) PROCESS.—The Commissioner shall establish a process to work with a State described in subparagraph (A) to provide assistance necessary to assure that the State's Exchange comes into compliance with the standards for approval under this section.

(c) CEASING OPERATION.—

(1) IN GENERAL.—A State-based Health Insurance Exchange may, at the option of each State involved, and only after providing timely and reasonable notice to the Commissioner, cease operation as such an Exchange, in which case the Health Insurance Exchange shall operate, instead of such State-based Health Insurance Exchange, with respect to such State (or States).

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Exchange under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such requirements of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

(3) EFFECTIVENESS.—The ceasing or termination of a State-based Health Insurance Exchange under this subsection shall be effective in such time and manner as the Commissioner shall specify.

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

(A) may not be performed by a State-based Health Insurance Exchange under this section; or

(B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(e) REFERENCES.—In the case of a State-based Health Insurance Exchange, except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be assistance provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 309. INTERSTATE HEALTH INSURANCE COMPACTS.

(a) IN GENERAL.—Effective January 1, 2015, 2 or more States may form Health Care Choice Compacts (in this section referred to as ''compacts'') to facilitate the purchase of individual health insurance coverage across State lines.

(b) MODEL GUIDELINES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall consult with the National Association of Insurance Commissioners (in this section referred to as ''NAIC'') to develop not later than January 1, 2014 model guidelines for the creation of compacts. In developing such guidelines, the Secretary shall consult with consumers, health insurance issuers, and other interested parties. Such guidelines shall—

(1) provide for the sale of health insurance coverage to residents of all compacting States subject to the laws and regulations of a primary State designated by the compacting States;

(2) require health insurance issuers issuing health insurance coverage in secondary States to maintain licensure in every such State;

(3) preserve the authority of the State of an individual's residence to enforce law relating to—

(A) market conduct;

(B) unfair trade practices;

(C) network adequacy;

(D) consumer protection standards;

(E) grievance and appeals;

(F) fair claims payment requirements;

(G) prompt payment of claims;

(H) rate review; and

(I) fraud;

(4) permit State insurance commissioners and other State agencies in secondary States access to the records of a health insurance issuer to the same extent as if the policy were written in that State; and

(5) provide for clear and conspicuous disclosure to consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(c) NO REQUIREMENT TO COMPACT.—Nothing in this section shall be construed to require a State to join a compact.

(d) STATE AUTHORITY.—A State may not enter into a compact under this subsection unless the State enacts a law after the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(e) CONSUMER PROTECTIONS.—If a State enters into a compact it must retain responsibility for the consumer protections of its residents and its residents retain the right to bring a claim in a State court in the State in which the resident resides.

(f) ASSISTANCE TO COMPACTING STATES.—

(1) IN GENERAL.—Beginning January 1, 2015, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—

(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available for grants under this subsection.

(B) STATE AMOUNT.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary, not to exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related regulating health insurance coverage sold in secondary States.

(4) RENEWABILITY OF GRANT.—The Secretary may renew a grant award under paragraph (1) if the State receiving the grant continues to be a member of a compact.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection in each of fiscal years 2015 through 2020.

SEC. 310. HEALTH INSURANCE COOPERATIVES.

(a) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this Act, the Commissioner, in consultation with the Secretary of the Treasury, shall establish a Consumer Operated and Oriented Plan program (in this section referred to as the ''CO–OP program'') under which the Commissioner may make grants and loans for the establishment and initial operation of not-for-profit, member–run health insurance cooperatives (in this section individually referred to as a ''cooperative'') that provide insurance through the Health Insurance Exchange or a State-based Health Insurance Exchange under section 308. Nothing in this section shall be construed as requiring a State to establish such a cooperative.

(b) START-UP AND SOLVENCY GRANTS AND LOANS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make—

(A) loans (of such period and with such terms as the Secretary may specify) to cooperatives to assist such cooperatives with start-up costs; and

(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) CONDITIONS.—A grant or loan may not be awarded under this subsection with respect to a cooperative unless the following conditions are met:

(A) The cooperative is structured as a not-for-profit, member organization under the law of each State in which such cooperative offers, intends to offer, or issues insurance coverage, with the membership of the cooperative being made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(B) The cooperative did not offer insurance on or before July 16, 2009, and the cooperative is not an affiliate or successor to an insurance company offering insurance on or before such date.

(C) The governing documents of the cooperative incorporate ethical and conflict of interest standards designed to protect against insurance industry involvement and interference in the governance of the cooperative.

(D) The cooperative is not sponsored by a State government.

(E) Substantially all of the activities of the cooperative consist of the issuance of qualified health benefits plans through the Health Insurance Exchange or a State-based health insurance exchange.

(F) The cooperative is licensed to offer insurance in each State in which it offers insurance.

(G) The governance of the cooperative must be subject to a majority vote of its members.

(H) As provided in guidance issued by the Secretary of Health and Human Services, the cooperative operates with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(I) Any profits made by the cooperative are used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to members.

(3) PRIORITY.—The Commissioner, in making grants and loans under this subsection, shall give priority to cooperatives that—

(A) operate on a statewide basis;

(B) use an integrated delivery system; or

(C) have a significant level of financial support from nongovernmental sources.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a cooperative established in one State from integrating with a cooperative established in another State the administration, issuance of coverage, or other activities related to acting as a QHBP offering entity. Nothing in this section shall be construed as preventing State governments from taking actions to permit such integration.

(5) AMORTIZATION OF GRANTS AND LOANS.—The Secretary shall provide for the repayment of grants or loans provided under this subsection to the Treasury in an amortized manner over a 10-year period.

(6) REPAYMENT FOR VIOLATIONS OF TERMS OF PROGRAM.—If a cooperative violates the terms of the CO–OP program and fails to correct the violation within a reasonable period of time, as determined by the Commissioner, the cooperative shall repay the total amount of any loan or grant received by such cooperative under this section, plus interest (at a rate determined by the Secretary).

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $5,000,000,000 for the period of fiscal years 2010 through 2014 to provide for grants and loans under this subsection.

(c) DEFINITIONS.—For purposes of this section:

(1) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(2) MEMBER.—The term ''member'', with respect to a cooperative, means an individual who, after the cooperative offers health insurance coverage, is enrolled in such coverage.

SEC. 311. RETENTION OF DOD AND VA AUTHORITY.

Nothing in this subtitle shall be construed as affecting any authority under title 38, United States Code, or chapter 55 of title 10, United States Code.

Subtitle B—Public Health Insurance Option

SEC. 321. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with Y1, the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the ''public health insurance option'') that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without compromising quality or access to care.

(b) OFFERING AS AN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—

(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost-sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

(A) shall offer basic, enhanced, and premium plans; and

(B) may offer premium-plus plans.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care. Nothing in this subtitle may be construed as authorizing the Secretary (or any employee or contractor) to create or maintain lists of non-medical personal property.

(f) TREATMENT OF PUBLIC HEALTH INSURANCE OPTION.—With respect to the public health insurance option, the Secretary shall be treated as a QHBP offering entity offering an Exchange-participating health benefits plan.

(g) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 322. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

(1) IN GENERAL.—The Secretary shall establish geographically adjusted premium rates for the public health insurance option—

(A) in a manner that complies with the premium rules established by the Commissioner under section 213 for Exchange-participating health benefits plans; and

(B) at a level sufficient to fully finance the costs of—

(i) health benefits provided by the public health insurance option; and

(ii) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall include an appropriate amount for a contingency margin (which shall be not less than 90 days of estimated claims). Before setting such appropriate amount for years starting with Y3, the Secretary shall solicit a recommendation on such amount from the American Academy of Actuaries.

(b) ACCOUNT.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States an Account for the receipts and disbursements attributable to the operation of the public health insurance option, including the start-up funding under paragraph (2). Section 1854(g) of the Social Security Act shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

(2) START-UP FUNDING.—

(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there are hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under subparagraph (A) to the Treasury in an amortized manner over the 10-year period beginning with Y1.

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

(3) NO BAILOUTS.—In no case shall the public health insurance option receive any Federal funds for purposes of insolvency in any manner similar to the manner in which entities receive Federal funding under the Troubled Assets Relief Program of the Secretary of the Treasury.

SEC. 323. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) NEGOTIATION OF PAYMENT RATES.—

(1) IN GENERAL.—The Secretary shall negotiate payment for the public health insurance option for health care providers and items and services, including prescription drugs, consistent with this section and section 324.

(2) MANNER OF NEGOTIATION.—The Secretary shall negotiate such rates in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHBP offering entities for services and health care providers.

(3) INNOVATIVE PAYMENT METHODS.—Nothing in this subsection shall be construed as preventing the use of innovative payment methods such as those described in section 324 in connection with the negotiation of payment rates under this subsection.

(4) TREATMENT OF CERTAIN STATE WAIVERS.—In the case of any State operating a cost-containment waiver for health care providers in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under the public health insurance option consistent with the provisions and requirements of that waiver.

(b) ESTABLISHMENT OF A PROVIDER NETWORK.—

(1) IN GENERAL.—Health care providers (including physicians and hospitals) participating in Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary consistent with this subsection.

(2) REQUIREMENTS FOR OPT-OUT PROCESS.—Under the process established under paragraph (1)—

(A) providers described in such paragraph shall be provided at least a 1-year period prior to the first day of Y1 to opt out of participating in the public health insurance option;

(B) no provider shall be subject to a penalty for not participating in the public health insurance option;

(C) the Secretary shall include information on how providers participating in Medicare who chose to opt out of participating in the public health insurance option may opt back in; and

(D) there shall be an annual enrollment period in which providers may decide whether to participate in the public health insurance option.

(3) RULEMAKING.—Not later than 18 months before the first day of Y1, the Secretary shall promulgate rules (pursuant to notice and comment) for the process described in paragraph (1).

(c) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 324.

SEC. 324. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(a) IN GENERAL.—For plan years beginning with Y1, the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.

(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficient and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

(2) promotes care that is integrated, patient-centered, quality, and efficient.

(c) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost-sharing and payment rates to encourage the use of services that promote health and value.

(d) PROMOTION OF DELIVERY SYSTEM REFORM.—The Secretary shall monitor and evaluate the progress of payment and delivery system reforms under this Act and shall seek to implement such reforms subject to the following:

(1) To the extent that the Secretary finds a payment and delivery system reform successful in improving quality and reducing costs, the Secretary shall implement such reform on as large a geographic scale as practical and economical.

(2) The Secretary may delay the implementation of such a reform in geographic areas in which such implementation would place the public health insurance option at a competitive disadvantage.

(3) The Secretary may prioritize implementation of such a reform in high cost geographic areas or otherwise in order to reduce total program costs or to promote high value care.

(e) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

SEC. 325. PROVIDER PARTICIPATION.

(a) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

(b) LICENSURE OR CERTIFICATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall not allow a health care provider to participate in the public health insurance option unless such provider is appropriately licensed, certified, or otherwise permitted to practice under State law.

(2) SPECIAL RULE FOR IHS FACILITIES AND PROVIDERS.—The requirements under paragraph (1) shall not apply to—

(A) a facility that is operated by the Indian Health Service;

(B) a facility operated by an Indian Tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638);

(C) a health care professional employed by the Indian Health Service; or

(D) a health care professional—

(i) who is employed to provide health care services in a facility operated by an Indian Tribe or tribal organization under the Indian Self-Determination Act; and

(ii) who is licensed or certified in any State.

(c) PAYMENT TERMS FOR PROVIDERS.—

(1) PHYSICIANS.—The Secretary shall provide for the annual participation of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment described in section 323 for such physicians) that exceed the sum of the in-network cost-sharing plus 15 percent of the total payment for each item and service. The Secretary shall reduce the payment described in section 323 for such physicians.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

(d) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from participation under the public health insurance option a health care provider that is excluded from

participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act).

SEC. 326. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

Provisions of civil law identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as sections 3729 through 3733 of title 31, United States Code (commonly known as the False Claims Act), shall also apply to the public health insurance option.

SEC. 327. APPLICATION OF HIPAA INSURANCE REQUIREMENTS.

The requirements of sections 2701 through 2792 of the Public Health Service Act shall apply to the public health insurance option in the same manner as they apply to health insurance coverage offered by a health insurance issuer in the individual market.

SEC. 328. APPLICATION OF HEALTH INFORMATION PRIVACY, SECURITY, AND ELECTRONIC TRANSACTION REQUIREMENTS.

Part C of title XI of the Social Security Act, relating to standards for protections against the wrongful disclosure of individually identifiable health information, health information security, and the electronic exchange of health care information, shall apply to the public health insurance option in the same manner as such part applies to other health plans (as defined in section 1171(5) of such Act).

SEC. 329. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION IS VOLUNTARY.

Nothing in this division shall be construed as requiring anyone to enroll in the public health insurance option. Enrollment in such option is voluntary.

SEC. 330. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION BY MEMBERS OF CONGRESS.

Notwithstanding any other provision of this Act, Members of Congress may enroll in the public health insurance option.

SEC. 331. REIMBURSEMENT OF SECRETARY OF VETERANS AFFAIRS.

The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Secretary of Veterans Affairs regarding the recovery of costs related to non-service-connected care or services provided by the Secretary of Veterans Affairs to an individual covered under the public health insurance option in a manner consistent with recovery of costs related to non-service-connected care from private health insurance plans.

Subtitle C—Individual Affordability Credits

SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, in the case of an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

(A) an affordability premium credit under section 343 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 344 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

(2) the Commissioner shall pay the QHBP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate amount of affordability credits for all affordable credit eligible individuals enrolled in such plan.

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle. The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding under section 305(e)(2)—

(A) the State Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination; and

(B) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(3) MEDICAID SCREEN AND ENROLL OBLIGATION.—In the case of an application made under paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding under section 305(e)(2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(4) APPLICATION AND VERIFICATION OF REQUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE IN THE UNITED STATES.—

(A) REQUIREMENT.—No individual shall be an affordable credit eligible individual (as defined in section 342(a)(1)) unless the individual is a citizen or national of the United States or is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act).

(B) DECLARATION OF CITIZENSHIP OR LAWFUL IMMIGRATION STATUS.—No individual shall be an affordable credit eligible individual unless there has been a declaration made, in a form and manner specified by the Health Choices Commissioner similar to the manner required under section 1137(d)(1) of the Social Security Act and under penalty of perjury, that the individual—

(i) is a citizen or national of the United States; or

(ii) is not such a citizen or national but is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act).

Such declaration shall be verified in accordance with subparagraph (C) or (D), as the case may be.

(C) VERIFICATION PROCESS FOR CITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(i), subject to clause (ii), section 1902(ee) of the Social Security Act shall apply to such declaration in the same manner as such section applies to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying section 1902(ee) of such Act under clause (i)—

(I) any reference in such section to a State is deemed a reference to the Commissioner (or other public entity making the eligibility determination);

(II) any reference to medical assistance or enrollment under a State plan is deemed a reference to provision of affordability credits under this subtitle;

(III) a reference to a newly enrolled individual under paragraph (2)(A) of such section is deemed a reference to an individual newly in receipt of an affordability credit under this subtitle;

(IV) approval by the Secretary shall not be required in applying paragraph (2)(B)(ii) of such section;

(V) paragraph (3) of such section shall not apply; and

(VI) before the end of Y2, the Health Choices Commissioner, in consultation with the Commissioner of Social Security, may extend the periods specified in paragraph (1)(B)(ii) of such section.

(D) VERIFICATION PROCESS FOR NONCITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(ii), subject to clause (ii), the verification procedures of paragraphs (2) through (5) of section 1137(d) of the Social Security Act shall apply to such declaration in the same manner as such procedures apply to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying such paragraphs of section 1137(d) of such Act under clause (i)—

(I) any reference in such paragraphs to a State is deemed a reference to the Health Choices Commissioner; and

(II) any reference to benefits under a program is deemed a reference to affordability credits under this subtitle.

(iii) APPLICATION TO STATE-BASED EXCHANGES.—In the case of the application of the verification process under this subparagraph to a State-based Health Insurance Exchange approved under section 308, section 1137(e) of such Act shall apply to the Health Choices Commissioner in relation to the State.

(E) ANNUAL REPORTS.—The Health Choices Commissioner shall report to Congress annually on the number of applicants for affordability credits under this subtitle, their citizenship or immigration status, and the disposition of their applications. Such report shall be made publicly available and shall include information on—

(i) the number of applicants whose declaration of citizenship or immigration status, name, or social security account number was not consistent with records maintained by the Commissioner of Social Security or the Department of Homeland Security and, of such applicants, the number who contested the inconsistency and sought to document their citizenship or immigration status, name, or social security account number or to correct the information maintained in such records and, of those, the results of such contestations; and

(ii) the administrative costs of conducting the status verification under this paragraph.

(F) GAO REPORT.—Not later than the end of Y2, the Comptroller General of the United States shall submit to the Committee on

Ways and Means, the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on the Judiciary of the House of Representatives and the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on the Judiciary of the Senate a report examining the effectiveness of the citizenship and immigration verification systems applied under this paragraph. Such report shall include an analysis of the following:

(i) The causes of erroneous determinations under such systems.

(ii) The effectiveness of the processes used in remedying such erroneous determinations.

(iii) The impact of such systems on individuals, health care providers, and Federal and State agencies, including the effect of erroneous determinations under such systems.

(iv) The effectiveness of such systems in preventing ineligible individuals from receiving for affordability credits.

(v) The characteristics of applicants described in subparagraph (E)(i).

(G) PROHIBITION OF DATABASE.—Nothing in this paragraph or the amendments made by paragraph (6) shall be construed as authorizing the Health Choices Commissioner or the Commissioner of Social Security to establish a database of information on citizenship or immigration status.

(H) INITIAL FUNDING.—

(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Commissioner of Social Security $30,000,000, to be available without fiscal year limit to carry out this paragraph and section 205(v) of the Social Security Act.

(ii) FUNDING LIMITATION.—In no case shall funds from the Social Security Administration's Limitation on Administrative Expenses be used to carry out activities related to this paragraph or section 205(v) of the Social Security Act.

(5) AGREEMENT WITH SOCIAL SECURITY COMMISSIONER.—

(A) IN GENERAL.—The Health Choices Commissioner shall enter into and maintain an agreement described in section 205(v)(2) of the Social Security Act with the Commissioner of Social Security.

(B) FUNDING.—The agreement entered into under subparagraph (A) shall, for each fiscal year (beginning with fiscal year 2013)—

(i) provide funds to the Commissioner of Social Security for the full costs of the responsibilities of the Commissioner of Social Security under paragraph (4), including—

(I) acquiring, installing, and maintaining technological equipment and systems necessary for the fulfillment of the responsibilities of the Commissioner of Social Security under paragraph (4), but only that portion of such costs that are attributable to such responsibilities; and

(II) responding to individuals who contest with the Commissioner of Social Security a reported inconsistency with records maintained by the Commissioner of Social Security or the Department of Homeland Security relating to citizenship or immigration status, name, or social security account number under paragraph (4);

(ii) based on an estimating methodology agreed to by the Commissioner of Social Security and the Health Choices Commissioner, provide such funds, within 10 calendar days of the beginning of the fiscal year for the first quarter and in advance for all subsequent quarters in that fiscal year; and

(iii) provide for an annual accounting and reconciliation of the actual costs incurred and the funds provided under the agreement.

(C) REVIEW OF ACCOUNTING.—The annual accounting and reconciliation conducted pursuant to subparagraph (B)(iii) shall be reviewed by the Inspectors General of the Social Security Administration and the Health Choices Administration, including an analysis of consistency with the requirements of paragraph (4).

(D) CONTINGENCY.—In any case in which agreement with respect to the provisions required under subparagraph (B) for any fiscal year has not been reached as of the first day of such fiscal year, the latest agreement with respect to such provisions shall be deemed in effect on an interim basis for such fiscal year until such time as an agreement relating to such provisions is subsequently reached. In any case in which an interim agreement applies for any fiscal year under this subparagraph, the Commissioner of Social Security shall, not later than the first day of such fiscal year, notify the appropriate Committees of the Congress of the failure to reach the agreement with respect to such provisions for such fiscal year. Until such time as the agreement with respect to such provisions has been reached for such fiscal year, the Commissioner of Social Security shall, not later than the end of each 90-day period after October 1 of such fiscal year, notify such Committees of the status of negotiations between such Commissioner and the Health Choices Commissioner in order to reach such an agreement.

(E) APPLICATION TO PUBLIC ENTITIES ADMINISTERING AFFORDABILITY CREDITS.—If the Health Choices Commissioner provides for the conduct of verifications under paragraph (4) through a public entity, the Health Choices Commissioner shall require the public entity to enter into an agreement with the Commissioner of Social Security which provides the same terms as the agreement described in this paragraph (and section 205(v) of the Social Security Act) between the Health Choices Commissioner and the Commissioner of Social Security, except that the Health Choices Commissioner shall be responsible for providing funds for the Commissioner of Social Security in accordance with subparagraphs (B) through (D).

(6) AMENDMENTS TO SOCIAL SECURITY ACT.—

(A) COORDINATION OF INFORMATION BETWEEN SOCIAL SECURITY ADMINISTRATION AND HEALTH CHOICES ADMINISTRATION.—

(i) IN GENERAL.—Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

''Coordination of Information With Health Choices Administration

''(v)(1) The Health Choices Commissioner may collect and use the names and social security account numbers of individuals as required to provide for verification of citizenship under subsection (b)(4)(C) of section 341 of the Affordable Health Care for America Act in connection with determinations of eligibility for affordability credits under such section.

''(2)(A) The Commissioner of Social Security shall enter into and maintain an agreement with the Health Choices Commissioner for the purpose of establishing, in compliance with the requirements of section 1902(ee) as applied pursuant to section 341(b)(4)(C) of the Affordable Health Care for America Act, a program for verifying information required to be collected by the Health Choices Commissioner under such section 341(b)(4)(C).

''(B) The agreement entered into pursuant to subparagraph (A) shall include such safeguards as are necessary to ensure the maintenance of confidentiality of any information disclosed for purposes of verifying information described in subparagraph (A) and to provide procedures for permitting the Health Choices Commissioner to use the information for purposes of maintaining the records of the Health Choices Administration.

''(C) The agreement entered into pursuant to subparagraph (A) shall provide that information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to the agreement shall be provided at such time, at such place, and in such manner as the Commissioner of Social Security determines appropriate.

''(D) Information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to an agreement entered into pursuant to subparagraph (A) shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out such agreement. Any officer or employee or former officer or employee of the Health Choices Commissioner, or any officer or employee or former officer or employee of a contractor of the Health Choices Commissioner, who, without the written authority of the Commissioner of Social Security, publishes or communicates any information in such individual's possession by reason of such employment or position as such an officer shall be guilty of a felony and, upon conviction thereof, shall be fined or imprisoned, or both, as described in section 208.

''(3) The agreement entered into under paragraph (2) shall provide for funding to the Commissioner of Social Security consistent with section 341(b)(5) of Affordable Health Care for America Act.

''(4) This subsection shall apply in the case of a public entity that conducts verifications under section 341(b)(4) of the Affordable Health Care for America Act and the obligations of this subsection shall apply to such an entity in the same manner as such obligations apply to the Health Choices Commissioner when such Commissioner is conducting such verifications.''.

(ii) CONFORMING AMENDMENT.—Section 205(c)(2)(C) of such Act (42 U.S.C. 405(c)(2)(C)) is amended by adding at the end the following new clause:

''(x) For purposes of the administration of the verification procedures described in section 341(b)(4) of the Affordable Health Care for America Act, the Health Choices Commissioner may collect and use social security account numbers as provided for in section 205(v)(1).''.

(B) IMPROVING THE INTEGRITY OF DATA AND EFFECTIVENESS OF SAVE PROGRAM.—Section 1137(d) of the Social Security Act (42 U.S.C. 1320b–7(d)) is amended by adding at the end the following new paragraphs:

''(6)(A) With respect to the use by any agency of the system described in subsection (b) by programs specified in subsection (b) or any other use of such system, the U.S. Citizenship and Immigration Services and any other agency charged with the management of the system shall establish appropriate safeguards necessary to protect and improve the integrity and accuracy of data relating to individuals by—

''(i) establishing a process through which such individuals are provided access to, and the ability to amend, correct, and update, their own personally identifiable information contained within the system;

''(ii) providing a written response, without undue delay, to any individual who has made such a request to amend, correct, or update such individual's own personally identifiable information contained within the system; and

''(iii) developing a written notice for user agencies to provide to individuals who are denied a benefit due to a determination of ineligibility based on a final verification determination under the system.

''(B) The notice described in subparagraph (A)(ii) shall include—

''(i) information about the reason for such notice;

''(ii) a description of the right of the recipient of the notice under subparagraph (A)(i) to contest such notice;

''(iii) a description of the right of the recipient under subparagraph (A)(i) to access and attempt to amend, correct, and update the recipient's own personally identifiable information contained within records of the system described in paragraph (3); and

''(iv) instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies.''.

(C) STREAMLINING ADMINISTRATION OF VERIFICATION PROCESS FOR UNITED STATES CITIZENS.—Section 1902(ee)(2) of the Social Security Act (42 U.S.C. 1396a(ee)(2)) is amended by adding at the end the following:

''(D) In carrying out the verification procedures under this subsection with respect to a State, if the Commissioner of Social Security determines that the records maintained by such Commissioner are not consistent with an individual's allegation of United States citizenship, pursuant to procedures which shall be established by the State in coordination with the Commissioner of Social Security, the Secretary of Homeland Security, and the Secretary of Health and Human Services—

''(i) the Commissioner of Social Security shall inform the State of the inconsistency;

''(ii) upon being so informed of the inconsistency, the State shall submit the information on the individual to the Secretary of Homeland Security for a determination of whether the records of the Department of Homeland Security indicate that the individual is a citizen;

''(iii) upon making such determination, the Department of Homeland Security shall inform the State of such determination; and

''(iv) information provided by the Commissioner of Social Security shall be considered as strictly confidential and shall only be used by the State and the Secretary of Homeland Security for the purposes of such verification procedures.

''(E) Verification of status eligibility pursuant to the procedures established under this subsection shall be deemed a verification of status eligibility for purposes of this title, title XXI, and affordability credits under section 341(b)(4) of the Affordable Health Care for America Act, regardless of the program in which the individual is applying for benefits.''.

(c) USE OF AFFORDABILITY CREDITS.—

(1) IN GENERAL.—In Y1 and Y2 an affordable credit eligible individual may use an affordability credit only with respect to a basic plan.

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability premium credit under section 343, but not the affordability cost-sharing credit under section 344, to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordability credit amount otherwise applicable if the individual had enrolled in a basic plan.

(3) PROHIBITION OF USE OF PUBLIC FUNDS FOR ABORTION COVERAGE.—An affordability credit may not be used for payment for services described in section 222(e)(4)(A).

(d) ACCESS TO DATA.—In carrying out this subtitle, the Commissioner shall request from the Secretary of the Treasury consistent with section 6103 of the Internal Revenue Code of 1986 such information as may be required to carry out this subtitle.

(e) NO CASH REBATES.—In no case shall an affordable credit eligible individual receive any cash payment as a result of the application of this subtitle.

SEC. 342. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term ''affordable credit eligible individual'' means, subject to subsection (b) and section 346, an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 412;

(B) with modified adjusted gross income below 400 percent of the Federal poverty level for a family of the size involved;

(C) who is not a Medicaid eligible individual, other than an individual during a transition period under section 302(d)(3)(B)(ii); and

(D) subject to paragraph (3), who is not enrolled in acceptable coverage (other than an Exchange-participating health benefits plan).

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of the same family who are affordable credit eligible individuals shall be treated as a single affordable credit individual eligible for the applicable credit for such a family under this subtitle.

(3) SPECIAL RULE FOR INDIANS.—Subparagraph (D) of paragraph (1) shall not apply to an individual who has coverage that is treated as acceptable coverage for purposes of section 59B(d)(2) of the Internal Revenue Code of 1986 but is not treated as acceptable coverage for purposes of this division.

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the term ''affordable credit eligible individual'' does not include a full-time employee of an employer if the employer offers the employee coverage (for the employee and dependents) as a full-time employee under a group health plan if the coverage and employer contribution under the plan meet the requirements of section 412.

(2) EXCEPTIONS.—

(A) FOR CERTAIN FAMILY CIRCUMSTANCES.—The Commissioner shall establish such exceptions and special rules in the case described in paragraph (1) as may be appropriate in the case of a divorced or separated individual or such a dependent of an employee who would otherwise be an affordable credit eligible individual.

(B) FOR UNAFFORDABLE EMPLOYER COVERAGE.—Beginning in Y2, in the case of full-time employees for which the cost of the employee premium for coverage under a group health plan would exceed 12 percent of current modified adjusted gross income (determined by the Commissioner on the basis of verifiable documentation), paragraph (1) shall not apply.

(c) INCOME DEFINED.—

(1) IN GENERAL.—In this title, the term ''income'' means modified adjusted gross income (as defined in section 59B of the Internal Revenue Code of 1986).

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) CLARIFICATION OF TREATMENT OF AFFORDABILITY CREDITS.—Affordability credits under this subtitle shall not be treated, for purposes of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to be a benefit provided under section 403 of such title.

SEC. 343. AFFORDABILITY PREMIUM CREDIT.

(a) IN GENERAL.—The affordability premium credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in an amount equal to the amount (if any) by which the reference premium amount specified in subsection (c), exceeds the affordable premium amount specified in subsection (b) for the individual, except that in no case shall the affordable premium credit exceed the premium for the plan.

(b) AFFORDABLE PREMIUM AMOUNT.—

(1) IN GENERAL.—The affordable premium amount specified in this subsection for an individual for the annual premium in a plan year shall be equal to the product of—

(A) the premium percentage limit specified in paragraph (2) for the individual based upon the individual's modified adjusted gross income for the plan year; and

(B) the individual's modified adjusted gross income for such plan year.

(2) PREMIUM PERCENTAGE LIMITS BASED ON TABLE.—The Commissioner shall establish premium percentage limits so that for individuals whose modified adjusted gross income is within an income tier specified in the table in subsection (d) such percentage limits shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier.

(c) REFERENCE PREMIUM AMOUNT.—The reference premium amount specified in this subsection for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium levels. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) TABLE OF PREMIUM PERCENTAGE LIMITS, ACTUARIAL VALUE PERCENTAGES, AND OUT-OF-POCKET LIMITS FOR Y1 BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subtitle, subject to paragraph (3) and section 346, the table specified in this subsection is as follows:

In the case of modified adjusted gross income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	The actuarial value percentage is—	The out-of-pocket limit for Y1 is—
133% through 150%	1.5%	3.0%	97%	$500
150% through 200%	3.0%	5.5%	93%	$1,000
200% through 250%	5.5%	8.0%	85%	$2,000
250% through 300%	8.0%	10.0%	78%	$4,000
300% through 350%	10.0%	11.0%	72%	$4,500
350% through 400%	11.0%	12.0%	70%	$5,000

(2) SPECIAL RULES.—For purposes of applying the table under paragraph (1):

(A) FOR LOWEST LEVEL OF INCOME.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133 percent of FPL.

(B) APPLICATION OF HIGHER ACTUARIAL VALUE PERCENTAGE AT TIER TRANSITION POINTS.—If two actuarial value percentages may be determined with respect to an individual, the actuarial value percentage shall be the higher of such percentages.

(3) INDEXING.—For years after Y1, the Commissioner shall adjust the initial and final premium percentages to maintain the ratio of governmental to enrollee shares of premiums over time, for each income tier identified in the table in paragraph (1).

SEC. 344. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's modified adjusted gross income.

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing specified in section 222(c)(2)(B) under a basic plan for each income tier specified in the table under section 343(d), with respect to a year, in a manner so that, as estimated by the Commissioner—

(1) the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual cost-sharing limit) is equal to the actuarial value percentage (specified in the table under section 343(d) for the income tier involved) of the full actuarial value if there were no cost-sharing imposed under the plan; and

(2) the annual limitation on cost-sharing specified in section 222(c)(2)(B) is reduced to a level that does not exceed the maximum out-of-pocket limit specified in subsection (c).

(c) MAXIMUM OUT-OF-POCKET LIMIT.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum out-of-pocket limit specified in this subsection for an individual within an income tier—

(A) for individual coverage—

(i) for Y1 is the out-of-pocket limit for Y1 specified in subsection (c) in the table under section 343(d) for the income tier involved; or

(ii) for a subsequent year is such out-of-pocket limit for the previous year under this subparagraph increased (rounded to the nearest $10) for each subsequent year by the percentage increase in the enrollment-weighted average of premium increases for basic plans applicable to such year; or

(B) for family coverage is twice the maximum out-of-pocket limit under subparagraph (A) for the year involved.

(2) ADJUSTMENT.—The Commissioner shall adjust the maximum out-of-pocket limits under paragraph (1) to ensure that such limits meet the actuarial value percentage specified in the table under section 343(d) for the income tier involved.

(d) DETERMINATION AND PAYMENT OF COST-SHARING AFFORDABILITY CREDIT.—In the case of an affordable credit eligible individual in a tier enrolled in an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner shall provide for payment to the offering entity of an amount equivalent to the increased actuarial value of the benefits under the plan provided under section 303(c)(2)(B) resulting from the reduction in cost-sharing described in subsections (b) and (c).

SEC. 345. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be the income (as defined in section 342(c)) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty level applied shall be such level in effect as of the date of the application.

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

(1) PROGRAM INTEGRITY.—The Commissioner shall take such steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 342(b)) or upon an application for a change in the affordability credit based upon a significant change in modified adjusted gross income described in subsection (c)(1)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be permitted to verify the information contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(B) ALTERNATIVE PROCEDURES.—The Commissioner shall establish procedures for the verification of income for purposes of this subtitle if no income tax return is available for the most recent completed tax year.

(c) SPECIAL RULES.—

(1) CHANGES IN INCOME AS A PERCENT OF FPL.—In the case that an individual's income (expressed as a percentage of the Federal poverty level for a family of the size involved) for a plan year is expected (in a manner specified by the Commissioner) to be significantly different from the income (as so expressed) used under subsection (a), the Commissioner shall establish rules requiring an individual to report, consistent with the mechanism established under paragraph (2), significant changes in such income (including a significant change in family composition) to the Commissioner and requiring the substitution of such income for the income otherwise applicable.

(2) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner when there is a significant change in the modified adjusted gross income of the individual (expressed as a percentage of the FPL for a family of the size involved) and of the information regarding such change. Such mechanism shall provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the modified adjusted gross income of the individual, the Commissioner shall provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

(3) TRANSITION FOR CHIP.—In the case of a child described in section 302(d)(4), the Commissioner shall establish rules under which the modified adjusted gross income of the child is deemed to be no greater than the family income of the child as most recently determined before Y1 by the State under title XXI of the Social Security Act.

(4) STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y1, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

(B) INCLUSION OF TERRITORIES.—

(i) IN GENERAL.—The Secretary shall ensure that the study under subparagraph (A) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

(ii) TERRITORIES DEFINED.—In this subparagraph, the term ''territories of the United States'' includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.

(d) PENALTIES FOR MISREPRESENTATION.—In the case of an individual who intentionally misrepresents modified adjusted gross income or the individual fails (without regard to intent) to disclose to the Commissioner a significant change in modified adjusted gross income under subsection (c) in a manner that results in the individual becoming an affordable credit eligible individual when the individual is not or in the amount of the affordability credit exceeding the correct amount—

(1) the individual is liable for repayment of the amount of the improper affordability credit; and

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

SEC. 346. SPECIAL RULES FOR APPLICATION TO TERRITORIES.

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

(1) IN GENERAL.—A territory may elect, in a form and manner specified by the Commissioner in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury and not later than October 1, 2012, either—

(A) to be treated as a State for purposes of applying this title and title II; or

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

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

(A) contingent upon entering into an agreement described in subsection (b) between the Commissioner and the territory and subsection (c); and

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

(3) DEFAULT RULE.—A territory failing to make such an election (or having an election

under paragraph (1)(A) not accepted under paragraph (2)) shall be treated as having made the election described in paragraph (1)(B).

(b) AGREEMENT FOR SUBSTITUTION OF PERCENTAGES FOR AFFORDABILITY CREDITS.—

(1) NEGOTIATION.—In the case of a territory making an election under subsection (a)(1)(A) (in this section referred to as an ''electing territory'') , the Commissioner, in consultation with the Secretaries of Health and Human Services and the Treasury, shall enter into negotiations with the government of such territory so that, before Y1, there is an agreement reached between the parties on the percentages that shall be applied under paragraph (2) for that territory. The Commissioner shall not enter into such an agreement unless—

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

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

(2) APPLICATION OF SUBSTITUTE PERCENTAGES AND DOLLAR AMOUNTS.—In the case of an electing territory, there shall be substituted in section 342(a)(1)(B) and in the table in section 341(d)(1) for 400 percent, 133 percent, and other percentages and dollar amounts specified in such table, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:

(A) NO INCOME GAP BETWEEN MEDICAID AND AFFORDABILITY CREDITS.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between income level at which medical assistance is available through Medicaid and the income level at which affordability credits are available.

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

(i) affordable credit eligible individuals residing in the territory bear the same out-of-pocket responsibility for premiums and cost-sharing in relation to average income for residents in that territory, as

(ii) the out-of-pocket responsibility for premiums and cost-sharing for affordable credit eligible individuals residing in the 50 States or the District of Columbia in relation to average income for such residents.

(3) SPECIAL RULES WITH RESPECT TO APPLICATION OF TAX AND PENALTY PROVISIONS.—The electing territory shall enact one or more laws under which provisions similar to the following provisions apply with respect to such territory:

(A) Section 59B of the Internal Revenue Code of 1986, except that any resident of the territory who is not an affordable credit eligible individual but who would be an affordable credit eligible individual if such resident were a resident of one of the 50 States (and any qualifying child residing with such individual) may be treated as covered by acceptable coverage.

(B) Section 4980H of the Internal Revenue Code of 1986 and section 502(c)(11) of the Employee Retirement Income Security Act of 1974.

(C) Section 3121(c) of the Internal Revenue Code of 1986.

(4) IMPLEMENTATION OF INSURANCE REFORM AND CONSUMER PROTECTION REQUIREMENTS.—The electing territory shall enact and implement such laws and regulations as may be required to apply the requirements of title II with respect to health insurance coverage offered in the territory.

(c) CAP ON ADDITIONAL EXPENDITURES.—

(1) IN GENERAL.—In entering into an agreement with an electing territory under subsection (b), the Commissioner shall ensure that the aggregate expenditures under this subtitle with respect to residents of such territory during the period beginning with Y1 and ending with 2019 will not exceed the cap amount specified in paragraph (2) for such territory. The Commissioner shall adjust from time to time the percentages applicable under such agreement as needed in order to carry out the previous sentence.

(2) CAP AMOUNT.—

(A) IN GENERAL.—The cap amount specified in this paragraph—

(i) for Puerto Rico is $3,700,000,000 increased by the amount (if any) elected under subparagraph (C); or

(ii) for another territory is the portion of $300,000,000 negotiated for such territory under subparagraph (B).

(B) NEGOTIATION FOR CERTAIN TERRITORIES.—The Commissioner in consultation with the Secretary of Health and Human Services shall negotiate with the governments of the territories (other than Puerto Rico) to allocate the amount specified in subparagraph (A)(ii) among such territories.

(C) OPTIONAL SUPPLEMENTATION FOR PUERTO RICO.—

(i) IN GENERAL.—Puerto Rico may elect, in a form and manner specified by the Secretary of Health and Human Services in consultation with the Commissioner to increase the dollar amount specified in subparagraph (A)(i) by up to $1,000,000,000.

(ii) OFFSET IN MEDICAID CAP.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease the dollar limitation otherwise applicable to Puerto Rico under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year by the additional aggregate payments the Secretary estimates will be payable under this section for the fiscal year because of such election.

(d) LIMITATION ON FUNDING.—In no case shall this section (including the agreement under subsection (b)) permit—

(1) the obligation of funds for expenditures under this subtitle for periods beginning on or after January 1, 2020; or

(2) any increase in the dollar limitation described in subsection (a)(1)(B) for any portion of any fiscal year occurring on or after such date.

SEC. 347. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States.

TITLE IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 401. INDIVIDUAL RESPONSIBILITY.

For an individual's responsibility to obtain acceptable coverage, see section 59B of the Internal Revenue Code of 1986 (as added by section 501 of this Act).

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 411. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

An employer meets the requirements of this section if such employer does all of the following:

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 202(b))) in accordance with section 412.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 412.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2, if an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 413.

SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARD EMPLOYEE AND DEPENDENT COVERAGE.

(a) IN GENERAL.—An employer meets the requirements of this section with respect to an employee if the following requirements are met:

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 411(1). In the case of an Exchange-eligible employer, the employer may offer such coverage either through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer timely pays to the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

(3) PROVISION OF INFORMATION.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section, including the following:

(A) The name, date, and employer identification number of the employer.

(B) A certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a current employment-based health plan (within the meaning of section 202(b)).

(C) If the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

(i) the months during the calendar year for which such coverage was available; and

(ii) the monthly premium for the lowest cost option in each of the enrollment categories under each such plan offered to employees.

(D) The name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such plans.

(4) AUTOENROLLMENT OF EMPLOYEES.—The employer provides for autoenrollment of the employee in accordance with subsection (c). This subsection shall supersede any law of a State which would prevent automatic payroll deduction of employee contributions to an employment-based health plan.

(b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH MINIMUM EMPLOYER CONTRIBUTION.—

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986)) under a qualified health benefits plan (or current employment-based health plan) is equal to—

(A) in case of individual coverage, not less than 72.5 percent of the applicable premium (as defined in section 4980B(f)(4) of such Code, subject to paragraph (2)) of the lowest cost plan offered by the employer that is a

qualified health benefits plan (or is such current employment-based health plan); and

(B) in the case of family coverage which includes coverage of such spouse and children, not less 65 percent of such applicable premium of such lowest cost plan.

(2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 343(c) for individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution under this subsection with respect to a full-time employee that reflects the proportion of—

(A) the average weekly hours of employment of the employee by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

(4) SALARY REDUCTIONS NOT TREATED AS EMPLOYER CONTRIBUTIONS.—For purposes of this section, any contribution on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer.

(c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPONSORED HEALTH BENEFITS.—

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll such employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

(2) OPT-OUT.—In no case may an employer automatically enroll an employee in a plan under paragraph (1) if such employee makes an affirmative election to opt out of such plan or to elect coverage under an employment-based health benefits plan offered by such employer. An employer shall provide an employee with a 30-day period to make such an affirmative election before the employer may automatically enroll the employee in such a plan.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—Each employer described in paragraph (1) who automatically enrolls an employee into a plan as described in such paragraph shall provide the employees, within a reasonable period before the beginning of each plan year (or, in the case of new employees, within a reasonable period before the end of the enrollment period for such a new employee), written notice of the employees' rights and obligations relating to the automatic enrollment requirement under such paragraph. Such notice must be comprehensive and understood by the average employee to whom the automatic enrollment requirement applies.

(B) INCLUSION OF SPECIFIC INFORMATION.—The written notice under subparagraph (A) must explain an employee's right to opt out of being automatically enrolled in a plan and in the case that more than one level of benefits or employee premium level is offered by the employer involved, the notice must explain which level of benefits and employee premium level the employee will be automatically enrolled in the absence of an affirmative election by the employee.

SEC. 413. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

(a) IN GENERAL.—A contribution is made in accordance with this section with respect to an employee if such contribution is equal to an amount equal to 8 percent of the average wages paid by the employer during the period of enrollment (determined by taking into account all employees of the employer and in such manner as the Commissioner provides, including rules providing for the appropriate aggregation of related employers) but not to exceed the minimum employer contribution described in section 412(b)(1)(A). Any such contribution—

(1) shall be paid to the Health Choices Commissioner for deposit into the Health Insurance Exchange Trust Fund; and

(2) shall not be applied against the premium of the employee under the Exchange-participating health benefits plan in which the employee is enrolled.

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—In the case of any employer who is a small employer for any calendar year, subsection (a) shall be applied by substituting the applicable percentage determined in accordance with the following table for ''8 percent'':

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $500,000	0 percent
Exceeds $500,000, but does not exceed $585,000	2 percent
Exceeds $585,000, but does not exceed $670,000	4 percent
Exceeds $670,000, but does not exceed $750,000	6 percent

(2) SMALL EMPLOYER.—For purposes of this subsection, the term ''small employer'' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.

(3) ANNUAL PAYROLL.—For purposes of this paragraph, the term ''annual payroll'' means, with respect to any employer for any calendar year, the aggregate wages paid by the employer during such calendar year.

(4) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

SEC. 414. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plan (within the meaning of section 202(b)) offered by the employer and instead to enroll in an Exchange-participating health benefits plan. An employer violating such standards shall be treated as not meeting the requirements of this section.

SEC. 415. IMPACT STUDY ON EMPLOYER RESPONSIBILITY REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Labor shall conduct a study to examine the effect of the exemptions under section 512(a) and coverage thresholds under this division (in this section referred to collectively as ''employer responsibility requirements'' on employment-based health plan sponsorship, generally and within specific industries, and the effect of such requirements and thresholds on employers, employment-based health plans, and employees in each industry.

(b) ANNUAL REPORT.—The Secretary of Labor annually shall submit to Congress a report on findings on how employer responsibility requirements have impacted and are likely to impact employers, plans, and employees during the previous year and projected trends.

(c) LEGISLATIVE RECOMMENDATIONS.—No later than January 1, 2012 and on an annual basis thereafter, the Secretary of Labor shall submit legislative recommendations to Congress to modify the employer responsibility requirements if the Secretary determines that the requirements are detrimentally affecting or will detrimentally affect employer plan sponsorship or otherwise creating inequities among employers, health plans, and employees. The Secretary may also submit such recommendations as the Secretary determines necessary to improve and strengthen employment-based health plan sponsorship, employer responsibility, and related proposals that would enhance the delivery of health care benefits between employers and employees.

SEC. 416. STUDY ON EMPLOYER HARDSHIP EXEMPTION.

(a) IN GENERAL.—The Secretary of Labor together with the Secretary of Treasury, the Secretary of Health and Human Services, and the Commissioner, shall conduct a study to examine the impact of the employer responsibility requirements described in section 415(a) and make a recommendation to Congress about whether an employer hardship exemption would be appropriate.

(b) ITEMS INCLUDED IN STUDY.—Within such study the Secretaries and Commissioner shall examine cases where such employer responsibility requirements may pose a particular hardship, and specifically look at employers by industry, profit margin, length of time in business, and size. In this examination, the economic conditions shall be considered, including the rate of increase in business costs, the availability of short-term credit lines, and abilities to restructure debt. In addition, the study shall examine the impact an employer hardship waiver could have on employees.

(c) REPORT.—Not later than January 1, 2012, the Secretaries and Commissioner shall report to Congress on their findings and make a recommendation regarding the need or lack of need for a partial or complete employer hardship waiver. The Secretaries and Commissioner may also submit recommendations about the criteria Congress should include when developing eligibility requirements for the employer hardship waiver and what safeguards are necessary to protect the employees of that employer.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 421. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

''(a) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

''(b) TIME AND MANNER.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

"SEC. 802. TREATMENT OF COVERAGE RESULTING FROM ELECTION.

''(a) IN GENERAL.—If an employer makes an election to the Secretary under section 801—

''(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

''(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

''(b) PERIODIC INVESTIGATIONS TO DISCOVER NONCOMPLIANCE.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to such sampling of plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

''(c) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The scope and content of such recordkeeping requirements shall be determined by the Secretary and shall be designed to ensure that employees who are not properly treated as such may be identified and properly treated.

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

''For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title IV of division A of (as in effect on the date of the enactment of such Act).

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

''(a) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election under section 801 shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

''(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

''(1) separate lines of business, and

''(2) full-time employees and employees who are not full-time employees.

"SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.

''The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

"SEC. 806. REGULATIONS.

''The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part, in accordance with section 424(a) of the . The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.''.

(b) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking ''paragraph'' and all that follows through ''subsection (c)'' and inserting ''paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)''; and

(2) in subsection (c), by redesignating the second paragraph (10) as paragraph (12) and by inserting after the first paragraph (10) the following new paragraph:

''(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(B) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this paragraph, the term 'health coverage participation requirements' has the meaning provided in section 803.

''(C) LIMITATIONS ON AMOUNT OF PENALTY.—

''(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

''(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

''(I) such failure was due to reasonable cause and not to willful neglect, and

''(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under subparagraph (A) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

''(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding 1-year period for group health plans, or

''(II) $500,000.

''(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 424 of the Affordable Health Care for America Act, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

''(F) DEPOSIT OF PENALTY COLLECTED.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous receipts in the Treasury of the United States.''.

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 734 the following new items:

''PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

''Sec. 801. Election of employer to be subject to national health coverage participation requirements.
''Sec. 802. Treatment of coverage resulting from election.
''Sec. 803. Health coverage participation requirements.
''Sec. 804. Rules for applying requirements.
''Sec. 805. Termination of election in cases of substantial noncompliance.
''Sec. 806. Regulations.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 422. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) FAILURE TO ELECT, OR SUBSTANTIALLY COMPLY WITH, HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For employment tax on employers who fail to elect, or substantially comply with, the health coverage participation requirements described in part 1, see section 3111(c) of the Internal Revenue Code of 1986 (as added by section 512 of this Act).

(b) OTHER FAILURES.—For excise tax on other failures of electing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 511 of this Act).

SEC. 423. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Part C of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

''(a) ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

''(2) TIME AND MANNER.—An election under paragraph (1) may be made at such time and in such form and manner as the Secretary may prescribe.

''(b) TREATMENT OF COVERAGE RESULTING FROM ELECTION.—

''(1) IN GENERAL.—If an employer makes an election to the Secretary under subsection (a)—

''(A) such election shall be treated as the establishment and maintenance of a group health plan for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

''(B) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

''(2) PERIODIC INVESTIGATIONS TO DETERMINE COMPLIANCE WITH HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—The Secretary shall regularly audit a representative sampling of employers and conduct investigations and other activities with respect to such sampling of employers so as to discover noncompliance with the health coverage participation requirements in connection with such employers (during any period with respect to which an election under subsection (a) is in effect). The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

''(3) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The scope and content of such recordkeeping requirements shall be determined by the Secretary and shall be designed to ensure that employees who are not properly treated as such may be identified and properly treated.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title IV of division A of the (as in effect on the date of the enactment of this section).

''(d) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under subsection (a) with respect to full-time employees and employees who are not full-time employees.

''(e) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under subsection (a) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

''(f) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF PENALTY.—

''(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under paragraph (1) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

''(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under paragraph (1) with respect to any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

''(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under paragraph (1) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

''(ii) $500,000.

''(3) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under paragraph (1) with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(4) ACTIONS TO ENFORCE ASSESSMENTS.—The Secretary may bring a civil action in any District Court of the United States to collect any civil penalty under this subsection.

''(5) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 424 of the Affordable Health Care for America Act, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under paragraph (1) in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

''(6) DEPOSIT OF PENALTY COLLECTED.—Any amount of penalty collected under this subsection shall be deposited as miscellaneous receipts in the Treasury of the United States.

''(g) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this section, in accordance with section 424(a) of the . The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this section.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to periods beginning after December 31, 2012.

SEC. 424. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

(1) regulations, rulings, and interpretations issued by such officers relating to the same matter over which two or more of such officers have responsibility under subpart B of part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, section 4980H of the Internal Revenue Code of 1986, and section 2793 of the Public Health Service Act are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such officers in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(b) MULTIEMPLOYER PLANS.—In the case of a group health plan that is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the regulations prescribed in accordance with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing employers of such plan. For purposes of this division, contributions made pursuant to a collective bargaining agreement or other agreement to such a group health plan shall be treated as amounts paid by the employer.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

''PART VIII—HEALTH CARE RELATED TAXES

''SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

''Subpart A—Tax on Individuals Without Acceptable Health Care Coverage

''Sec. 59B. Tax on individuals without acceptable health care coverage.

''SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

''(a) TAX IMPOSED.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the excess of—

''(1) the taxpayer's modified adjusted gross income for the taxable year, over

''(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

''(b) LIMITATIONS.—

''(1) TAX LIMITED TO AVERAGE PREMIUM.—

''(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

''(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

''(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the case of any taxpayer who fails to meet the requirements of subsection (d) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

''(2) PRORATION FOR PART YEAR FAILURES.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as—

''(A) the aggregate periods during such taxable year for which such individual failed to meet the requirements of subsection (d), bears to

''(B) the entire taxable year.

''(c) EXCEPTIONS.—

''(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for any taxable year beginning in the same calendar year as such taxable year.

''(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a nonresident alien.

''(3) INDIVIDUALS RESIDING OUTSIDE UNITED STATES.—Any qualified individual (as defined in section 911(d)) (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1), whichever is applicable.

''(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

''(5) RELIGIOUS CONSCIENCE EXEMPTION.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

''(B) EXEMPTION.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such form and manner as the Secretary may prescribe. The Secretary may treat an application for exemption under section 1402(g)(1) as an application for exemption under this section, or may otherwise coordinate applications under such sections, as the Secretary determines appropriate. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

''(d) ACCEPTABLE COVERAGE REQUIREMENT.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any individual for any period if such individual (and each qualifying child of such individual) is covered by acceptable coverage at all times during such period.

''(2) ACCEPTABLE COVERAGE.—For purposes of this section, the term 'acceptable coverage' means any of the following:

''(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the).

''(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRANDFATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202 of the Affordable Health Care for America Act) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

''(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

''(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code.

''(G) MEMBERS OF INDIAN TRIBES.—Health care services made available through the Indian Health Service, a tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), or an urban Indian organization (as defined in such section) to members of an Indian tribe (as defined in such section).

''(H) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

''(e) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) QUALIFYING CHILD.—For purposes of this section, the term 'qualifying child' has the meaning given such term by section 152(c). With respect to any period during which health coverage for a child must be provided by an individual pursuant to a child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

''(2) BASIC PLAN.—For purposes of this section, the term 'basic plan' has the meaning given such term under section 100(c) of the Affordable Health Care for America Act.

''(3) HEALTH INSURANCE EXCHANGE.—For purposes of this section, the term 'Health Insurance Exchange' has the meaning given such term under section 100(c) of the Affordable Health Care for America Act, including any State-based health insurance exchange approved for operation under section 308 of such Act.

''(4) FAMILY COVERAGE.—For purposes of this section, the term 'family coverage' means any coverage other than self-only coverage.

''(5) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income increased by—

''(A) any amount excluded from gross income under section 911, and

''(B) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

''(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

''(2) a waiver of the application of subsection (a) in cases of hardship, including a process for applying for such a waiver.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after section 6050W the following new section:

''SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

''(a) REQUIREMENT OF REPORTING.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

''(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

''(C) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.''.

(2) PENALTY FOR FAILURE TO FILE.—

(A) RETURN.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by adding at the end the following new clause:

''(xxiv) section 6050X (relating to returns relating to health insurance coverage), and''.

(B) STATEMENT.—Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'', and by inserting after subparagraph (FF) the following new subparagraph:

''(GG) section 6050X (relating to returns relating to health insurance coverage).''.

(c) RETURN REQUIREMENT.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

''(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.''.

(d) CLERICAL AMENDMENTS.—

(1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. HEALTH CARE RELATED TAXES.''.

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050X. Returns relating to health insurance coverage.''.

(e) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

(2) RETURNS.—The amendments made by subsection (b) shall apply to calendar years beginning after December 31, 2012.

Subpart B—Employer Responsibility

SEC. 511. ELECTION TO SATISFY HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

''(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

''(1) IN GENERAL.—Subsection (b) shall apply to any employer with respect to whom an election under paragraph (2) is in effect.

''(2) TIME AND MANNER.—An employer may make an election under this paragraph at such time and in such form and manner as the Secretary may prescribe.

''(3) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414, the election under paragraph (2) shall be made by such person as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

''(4) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

''(A) separate lines of business, and

''(B) full-time employees and employees who are not full-time employees.

''(5) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

''(b) EXCISE TAX WITH RESPECT TO FAILURE TO MEET HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee to whom such election applies, there is hereby imposed on each such failure with respect to each such employee a tax of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF TAX.—

''(A) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that such failure existed.

''(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

''(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for employment-based health plans, or

''(ii) $500,000.

''(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 2793(g) of the Public Health Service Act with respect to such failure.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part I of subtitle B of title IV of the (as in effect on the date of the enactment of this section).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980H. Election with respect to health coverage participation requirements.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 512. HEALTH CARE CONTRIBUTIONS OF NONELECTING EMPLOYERS.

(a) IN GENERAL.—Section 3111 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

''(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

''(A) IN GENERAL.—In the case of any employer who is small employer for any calendar year, paragraph (1) shall be applied by substituting the applicable percentage determined in accordance with the following table for '8 percent':

"If the annual payroll of such employer for the preceding calendar year:	**The applicable percentage is:**
Does not exceed $500,000	0 percent
Exceeds $500,000, but does not exceed $585,000	2 percent
Exceeds $585,000, but does not exceed $670,000	4 percent
Exceeds $670,000, but does not exceed $750,000	6 percent

''(B) SMALL EMPLOYER.—For purposes of this paragraph, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.

''(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)) during such calendar year.

''(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term 'nonelecting employer' means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

''(5) AGGREGATION; PREDECESSORS.—For purposes of this subsection—

''(A) all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer, and

''(B) any reference to any person shall be treated as including a reference to any predecessor of such person.''.

(b) DEFINITIONS.—Section 3121 of such Code is amended by adding at the end the following new subsection:

''(aa) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3111(c)—

''(1) Paragraphs (1), (5), and (19) of subsection (b) shall not apply.

''(2) Paragraph (7) of subsection (b) shall apply by treating all services as not covered by the retirement systems referred to in subparagraphs (C) and (F) thereof.

''(3) Subsection (e) shall not apply and the term 'State' shall include the District of Columbia.''.

(c) CONFORMING AMENDMENT.—Subsection (d) of section 3111 of such Code, as redesignated by this section, is amended by striking ''this section'' and inserting ''subsections (a) and (b)''.

(d) APPLICATION TO RAILROADS.—

(1) IN GENERAL.—Section 3221 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.

''(2) EXCEPTION FOR SMALL EMPLOYERS.—Rules similar to the rules of section 3111(c)(2) shall apply for purposes of this subsection.

''(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term 'nonelecting employer' means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the compensation paid to employees who are not subject to such election.''.

(2) DEFINITIONS.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3221(c)—

''(A) Paragraph (1) shall be applied without regard to the third sentence thereof.

''(B) Paragraph (2) shall not apply.''.

(3) CONFORMING AMENDMENT.—Subsection (d) of section 3221 of such Code, as redesignated by this section, is amended by striking ''subsections (a) and (b), see section 3231(e)(2)'' and inserting ''this section, see paragraphs (2) and (13)(B) of section 3231(e)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

''SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

''(a) IN GENERAL.—For purposes of section 38, in the case of a qualified small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

''(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

''(c) LIMITATIONS.—

''(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as—

''(A) the excess of—

''(i) the number of qualified employees employed by the employer during the taxable year, over

''(ii) 10, bears to

''(B) 15.

''(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No credit shall be determined under subsection (a) with respect to qualified employee health coverage expenses paid or incurred with respect to any employee for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $80,000.

''(3) CREDIT ALLOWED FOR ONLY 2 TAXABLE YEARS.—No credit shall be determined under subsection (a) with respect to any employer for any taxable year unless the employer elects to have this section apply for such taxable year. An employer may elect the application of this section with respect to not more than 2 taxable years.

''(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified employee health coverage expenses' means, with respect to any employer for any taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage.

''(2) QUALIFIED HEALTH COVERAGE.—The term 'qualified health coverage' means acceptable coverage (as defined in section 59B(d)) which—

''(A) is provided pursuant to an election under section 4980H(a), and

''(B) satisfies the requirements referred to in section 4980H(c).

''(e) OTHER DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' means any employer for any taxable year if—

''(A) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

''(B) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

''(2) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation from such employer for services performed in the trade or business of such employer during such taxable year.

''(3) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term 'average annual employee compensation' means, with respect to any employer for any taxable year, the average amount of compensation paid by such employer to qualified employees of such employer during such taxable year.

''(4) COMPENSATION.—The term 'compensation' has the meaning given such term in section 408(p)(6)(A).

''(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(f) SPECIAL RULES.—For purposes of this section—

''(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined without regard to this paragraph) with respect to whom the election under section 4980H(a) applies, each partner (or, in the case of a trade or business carried on by an individual, such individual) shall be treated as an employee.

''(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(3) PREDECESSORS.—Any reference in this section to an employer shall include a reference to any predecessor of such employer.

''(4) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance coverage to which subsection (a) applies shall be reduced by the amount of the credit determined under this section.

''(5) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each of the dollar amounts in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) 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 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'' , and by adding at the end the following new paragraph:

''(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business employee health coverage credit determined under section 45R(a).''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 45Q the following new item:

''Sec. 45R. Small business employee health coverage credit.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

SEC. 531. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.''.

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of such Code is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug or is insulin.''.

(d) EFFECTIVE DATES.—The amendment made by this section shall apply to expenses incurred after December 31, 2010.

SEC. 532. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

''(2) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) 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 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 533. INCREASE IN PENALTY FOR NON-QUALIFIED DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subparagraph (A) of section 223(f)(4) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 534. DENIAL OF DEDUCTION FOR FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS WHICH HAVE BEEN EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2012.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

SEC. 541. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

(a) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.—

''(A) IN GENERAL.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 308 of the Affordable Health Care for America Act, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

''(iv) the number of dependents of the taxpayer,

''(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

''(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act and providing for the repayment of any such credit which was in excess of such appropriate amount.''.

(b) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A),'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20),'' both places it appears in the matter after subparagraph (F).

(c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 542. OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) CERTAIN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS NOT QUALIFIED.—

''(A) IN GENERAL.—The term 'qualified benefit' shall not include any exchange-participating health benefits plan (as defined in section 101(c) of the Affordable Health Care for America Act).

''(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is an exchange-eligible employer (as defined in section 302 of the Affordable Health Care for America Act).''.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking ''For purposes of this section, the term'' and inserting ''For purposes of this section—

''(1) IN GENERAL.—The term'', and

(2) by striking ''Such term shall not include'' and inserting the following:

''(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 543. EXCLUSION FROM GROSS INCOME OF PAYMENTS MADE UNDER REINSURANCE PROGRAM FOR RETIREES.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended—

(1) by striking ''Gross income'' and inserting the following:

''(a) FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.—Gross income'', and

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

''(b) FEDERAL REINSURANCE PROGRAM FOR RETIREES.—A rule similar to the rule of subsection (a) shall apply with respect to payments made under section 111 of the Affordable Health Care for America Act.''.

(b) CONFORMING AMENDMENT.—The heading of section 139A of such Code (and the item relating to such section in the table of sections for part III of subchapter B of chapter 1 of such Code) is amended by inserting ''**AND RETIREE HEALTH PLANS**'' after ''**PRESCRIPTION DRUG PLANS**''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 544. CLASS PROGRAM TREATED IN SAME MANNER AS LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Subsection (f) of section 7702B of the Internal Revenue Code of 1986 is amended—

(1) by striking ''State long-term care plan'' in paragraph (1)(A) and inserting ''government long-term care plan'',

(2) by redesignating paragraph (2) as paragraph (3), and

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

''(2) GOVERNMENT LONG-TERM CARE PLAN.—For purposes of this subsection, the term 'government long-term care plan' means—

''(A) the CLASS program established under title XXXII of the Public Health Service Act, and

''(B) any State long-term care plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (3) of section 7702B(f) of such Code, as redesignated by subsection (a), is amended by striking ''paragraph (1)'' and inserting ''this subsection''.

(2) Subsection (f) of section 7702(B) of such Code is amended by striking ''STATE-MAINTAINED'' in the heading thereof and inserting ''GOVERNMENT''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2010.

SEC. 545. EXCLUSION FROM GROSS INCOME FOR MEDICAL CARE PROVIDED FOR INDIANS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

''SEC. 139D. MEDICAL CARE PROVIDED FOR INDIANS.

''(a) IN GENERAL.—Gross income does not include—

''(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the Indian Health Service,

''(2) medical care provided by an Indian tribe or tribal organization to a member of an Indian tribe (including for this purpose, to the member's spouse or dependents) through any one of the following: provided or purchased medical care services; accident or health insurance (or an arrangement having the effect of accident or health insurance); or amounts paid, directly or indirectly, to reimburse the member for expenses incurred for medical care,

''(3) the value of accident or health plan coverage provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe (including for this purpose, coverage that extends to such member's spouse or dependents) under an accident or health plan (or through an arrangement having the effect of accident or health insurance), and

''(4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for the programs and services provided by the Federal Government to Indian tribes or Indians.

''(b) DEFINITIONS.—For purposes of this section—

''(1) IN GENERAL.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in sections 104 and 106.

''(2) MEDICAL CARE.—The term 'medical care' has the meaning given such term in section 213.

''(3) DEPENDENT.—The term 'dependent' has the meaning given such term in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B).

''(4) INDIAN TRIBE.—The term 'Indian tribe' means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

''(5) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).''.

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Medical care provided for Indians.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to health benefits and coverage provided after the date of enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by Indian tribes that are not within the scope of this section, and

(2) health benefits or coverage provided by Indian tribes prior to the effective date of this section.

Subtitle B—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

SEC. 551. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Part VIII of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as added by this title, is amended by adding at the end the following new subpart:

''Subpart B—Surcharge on High Income Individuals

''Sec. 59C. Surcharge on high income individuals.

''SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of subparts for part VIII of subchapter A of chapter 1 of such Code, as added by this title, is amended by inserting after the item relating to subpart A the following new item:

''SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 552. EXCISE TAX ON MEDICAL DEVICES.

(a) IN GENERAL.—Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter D—Medical Devices

''Sec. 4061. Medical devices.

''SEC. 4061. MEDICAL DEVICES.

''(a) IN GENERAL.—There is hereby imposed on the first taxable sale of any medical device a tax equal to 2.5 percent of the price for which so sold.

''(b) FIRST TAXABLE SALE.—For purposes of this section—

''(1) IN GENERAL.—The term 'first taxable sale' means the first sale, for a purpose other than for resale, after production, manufacture, or importation.

''(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of any medical device if—

''(A) such sale is made at a retail establishment on terms which are available to the general public, and

''(B) such medical device is of a type (and purchased in a quantity) which is purchased by the general public.

''(3) EXCEPTION FOR EXPORTS, ETC.—Rules similar to the rules of sections 4221 (other than paragraphs (3), (4), (5), and (6) of subsection (a) thereof) and 4222 shall apply for purposes of this section. To the extent provided by the Secretary, section 4222 may be extended to, and made applicable with respect to, the exemption provided by paragraph (2).

''(4) SALES TO PATIENTS NOT TREATED AS RESALES.—If a medical device is sold for use in connection with providing any health care service to an individual, such sale shall not be treated as being for the purpose of resale (even if such device is sold to such individual).

''(c) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) MEDICAL DEVICE.—The term 'medical device' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

''(2) LEASE TREATED AS SALE.—Rules similar to the rules of section 4217 shall apply.

''(3) USE TREATED AS SALE.—

''(A) IN GENERAL.—If any person uses a medical device before the first taxable sale of such device, then such person shall be liable for tax under such subsection in the same manner as if such use were the first taxable sale of such device.

''(B) EXCEPTIONS.—The preceding sentence shall not apply to—

''(i) use of a medical device as material in the manufacture or production of, or as a component part of, another medical device to be manufactured or produced by such person, or

''(ii) use of a medical device after a sale described in subsection (b)(2).

''(4) DETERMINATION OF PRICE.—

''(A) IN GENERAL.—Rules similar to the rules of subsections (a), (c), and (d) of section 4216 shall apply for purposes of this section.

''(B) CONSTRUCTIVE SALE PRICE.—If—

''(i) a medical device is sold (otherwise than through an arm's length transaction) at less than the fair market price, or

''(ii) a person is liable for tax for a use described in paragraph (3),

the tax under this section shall be computed on the price for which such or similar devices are sold in the ordinary course of trade as determined by the Secretary.

''(5) RESALES PURSUANT TO CERTAIN CONTRACT ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of a specified contract sale of a medical device, the seller referred to in subparagraph (B)(i) shall be entitled to recover from the producer, manufacturer, or importer referred to in subparagraph (B)(ii) the amount of the tax paid by such seller under this section with respect to such sale.

''(B) SPECIFIED CONTRACT SALE.—For purposes of this paragraph, the term 'specified contract sale' means, with respect to any medical device, the first taxable sale of such device if—

''(i) the seller is not the producer, manufacturer, or importer of such device, and

''(ii) the price at which such device is so sold is determined in accordance with a contract between the producer, manufacturer, or importer of such device and the person to whom such device is so sold.

''(C) SPECIAL RULES RELATED TO CREDITS AND REFUNDS.—In the case of any credit or refund under section 6416 of the tax imposed under this section on a specified contract sale of a medical device—

''(i) such credit or refund shall be allowed or made only if the seller has filed with the Secretary the written consent of the producer, manufacturer, or importer referred to in subparagraph (B)(ii) to the allowance of such credit or the making of such refund, and

''(ii) the amount of tax taken into account under subparagraph (A) shall be reduced by the amount of such credit or refund.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6416(b) of such Code is amended—

(A) by inserting ''or 4061'' after ''under section 4051'', and

(B) by adding at the end the following: ''In the case of the tax imposed by section 4061, subparagraphs (B), (C), (D), and (E) shall not apply.''.

(2) The table of subchapters for chapter 31 of such Code is amended by adding at the end the following new item:

''SUBCHAPTER D. MEDICAL DEVICES.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales (and leases and uses treated as sales) after December 31, 2012.

SEC. 553. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

''(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section

6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''amounts in consideration for property,'' after ''wages,'',

(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and

(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 554. REPEAL OF WORLDWIDE ALLOCATION OF INTEREST.

(a) IN GENERAL.—Section 864 of the Internal Revenue Code of 1986 is amended by striking subsection (f) and by redesignating subsection (g) as subsection (f).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 555. EXCLUSION OF UNPROCESSED FUELS FROM THE CELLULOSIC BIOFUEL PRODUCER CREDIT.

(a) IN GENERAL.—Subparagraph (E) of section 40(b)(6) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) EXCLUSION OF UNPROCESSED FUELS.—The term 'cellulosic biofuel' shall not include any fuel if—

''(I) more than 4 percent of such fuel (determined by weight) is any combination of water and sediment, or

''(II) the ash content of such fuel is more than 1 percent (determined by weight).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to fuels sold or used after the date of the enactment of this Act.

PART 2—PREVENTION OF TAX AVOIDANCE

SEC. 561. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) IN GENERAL.—Section 894 of the Internal Revenue Code of 1986 (relating to income affected by treaty) is amended by adding at the end the following new subsection:

''(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

''(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

''(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term 'deductible related-party payment' means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are members of the same foreign controlled group of entities.

''(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'foreign controlled group of entities' means a controlled group of entities the common parent of which is a foreign corporation.

''(B) CONTROLLED GROUP OF ENTITIES.—The term 'controlled group of entities' means a controlled group of corporations as defined in section 1563(a)(1), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

''(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

''(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term 'foreign parent corporation' means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

''(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

''(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

''(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 562. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; PENALTIES.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

''(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

''(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

''(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

''(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

''(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

''(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

''(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

''(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

''(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

''(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

''(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

''(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.''.

(b) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

(1) IN GENERAL.—Subsection (b) of section 6662 of such Code is amended by inserting after paragraph (5) the following new paragraph:

''(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.''.

(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

''(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

''(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

''(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a transaction described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

''(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.''.

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(A) by striking ''section 6662(h)'' and inserting ''subsections (h) or (i) of section 6662'', and

(B) by striking ''GROSS VALUATION MISSTATEMENT PENALTY'' in the heading and inserting ''CERTAIN INCREASED UNDERPAYMENT PENALTIES''.

(c) REASONABLE CAUSE EXCEPTION NOT APPLICABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS AND TAX SHELTERS.—

(1) REASONABLE CAUSE EXCEPTION FOR UNDERPAYMENTS.—Subsection (c) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking ''paragraph (2)'' in paragraph (4)(A), as so redesignated, and inserting ''paragraph (3)'', and

(C) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).''.

(2) REASONABLE CAUSE EXCEPTION FOR REPORTABLE TRANSACTION UNDERSTATEMENTS.—Subsection (d) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking ''paragraph (2)(C)'' in paragraph (4), as so redesignated, and inserting ''paragraph (3)(C)'', and

(C) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of a reportable transaction understatement which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).''.

(d) APPLICATION OF PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

(2) UNDERPAYMENTS.—The amendments made by subsections (b) and (c)(1) shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(3) UNDERSTATEMENTS.—The amendments made by subsection (c)(2) shall apply to understatements attributable to transactions entered into after the date of the enactment of this Act.

(4) REFUNDS AND CREDITS.—The amendment made by subsection (d) shall apply to refunds and credits attributable to transactions entered into after the date of the enactment of this Act.

SEC. 563. CERTAIN LARGE OR PUBLICLY TRADED PERSONS MADE SUBJECT TO A MORE LIKELY THAN NOT STANDARD FOR AVOIDING PENALTIES ON UNDERPAYMENTS.

(a) IN GENERAL.—Subsection (c) of section 6664 of the Internal Revenue Code of 1986, as amended by section 562, is amended—

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

(2) by striking ''paragraph (3)'' in paragraph (4)(A), as so redesignated, and inserting ''paragraph (4)'', and

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

''(3) SPECIAL RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

''(A) IN GENERAL.—In the case of any specified person, paragraph (1) shall apply to the portion of an underpayment which is attributable to any item only if such person has a reasonable belief that the tax treatment of such item by such person is more likely than not the proper tax treatment of such item.

''(B) SPECIFIED PERSON.—For purposes of this paragraph, the term 'specified person' means—

''(i) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

''(ii) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of clause (ii).''.

(b) NONAPPLICATION OF SUBSTANTIAL AUTHORITY AND REASONABLE BASIS STANDARDS FOR REDUCING UNDERSTATEMENTS.—Paragraph (2) of section 6662(d) of such Code is amended by adding at the end the following new subparagraph:

''(D) REDUCTION NOT TO APPLY TO CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subparagraph (B) shall not apply to any specified person (as defined in section 6664(c)(3)(B)).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(2) NONAPPLICATION OF UNDERSTATEMENT REDUCTION.—The amendment made by subsection (b) shall apply to understatements attributable to transactions entered into after the date of the enactment of this Act.

PART 3—PARITY IN HEALTH BENEFITS

SEC. 571. CERTAIN HEALTH RELATED BENEFITS APPLICABLE TO SPOUSES AND DEPENDENTS EXTENDED TO ELIGIBLE BENEFICIARIES.

(a) APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.—

(1) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans), as amended by section 531, is amended by adding at the end the following new subsection:

''(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

''(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

''(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'eligible beneficiary' means any individual who is eligible to receive benefits or coverage under an accident or health plan.''.

(2) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of such Code (relating to amounts expended for medical care) is amended—

(A) by striking ''and his dependents'' and inserting ''his dependents'', and

(B) by inserting before the period the following: ''and any eligible beneficiary (within the meaning of section 106(g)) with respect to the taxpayer''.

(3) PAYROLL TAXES.—

(A) Section 3121(a)(2) of such Code is amended—

(i) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'',

(ii) by striking ''or any of his dependents,'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(iii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(B) Section 3231(e)(1) of such Code is amended—

(i) by striking ''or any of his dependents'' and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(ii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(C) Section 3306(b)(2) of such Code is amended—

(i) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'',

(ii) by striking ''or any of his dependents'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'', and

(iii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(D) Section 3401(a) of such Code is amended by striking ''or'' at the end of paragraph (22), by striking the period at the end of paragraph (23) and inserting ''; or'', and by inserting after paragraph (23) the following new paragraph:

''(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(g).''.

(b) EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

''(A) the taxpayer,

''(B) the taxpayer's spouse,

''(C) the taxpayer's dependents,

''(D) any individual who—

''(i) satisfies the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

''(iii) meets the requirements of section 152(d)(1)(C), and

''(E) one individual who—

''(i) does not satisfy the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

''(iii) meets the requirements of section 152(d)(1)(D), and

''(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).''.

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(l)(2) of such Code is amended by inserting '', any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to'' after ''spouse''.

(c) EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO

MEMBERS OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.—Section 501(c)(9) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new sentence: ''For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term 'dependents' shall include any individual who is an eligible beneficiary (within the meaning of section 106(g)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.''.

(d) FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's flexible spending arrangement, notwithstanding the fact that such expenses are attributable to any individual who is not the employee's spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's health reimbursement arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the health reimbursement arrangement with respect to the employee.

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

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 1001. TABLE OF CONTENTS OF DIVISION.

The table of contents of this division is as follows:

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (III), by striking ''and'' at the end;

(2) by redesignating subclause (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2010, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2010.

SEC. 1102. INPATIENT REHABILITATION FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C.

1395ww(j)(3)(C)) is amended by striking ''and 2009'' and inserting ''through 2010''.

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (iii)—

(A) by striking ''(iii) For purposes of this subparagraph,'' and inserting ''(iii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (II),''; and

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

''(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset in the form of a reduction in such increase or change equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published in final form before the promulgation or publication of such increase for the year or period involved). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in subclause (I) minus the percentage change under this subclause.'';

(2) in the first sentence of clause (viii)(I), by inserting ''(but not below zero)'' after ''shall be reduced''; and

(3) in the first sentence of clause (ix)(I)—

(A) by inserting ''(determined without regard to clause (iii)(II))'' after ''clause (i)'' the second time it appears; and

(B) by inserting ''(but not below zero)'' after ''reduced''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5)(B)) is amended by inserting ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' after ''as calculated by the Secretary''.

(c) LONG TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

''(3) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring on or after January 1, 2010, during the rate year ending in 2010 or any subsequent rate year for a hospital, to the extent that an annual percentage increase factor applies to a standard Federal rate for such discharges for the hospital, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).''.

(d) INPATIENT REHABILITATION FACILITIES.—The second sentence of section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by inserting ''(subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II))'' after ''appropriate percentage increase''.

(e) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

''(2) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for days occurring during the rate year ending in 2011 or any subsequent rate year for a psychiatric hospital or unit described in such paragraph, to the extent that an annual percentage increase factor applies to a base rate for such days for the hospital or unit, respectively, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).''.

(f) HOSPICE CARE.—Subclause (VII) of section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended by inserting after ''the market basket percentage increase'' the following: ''(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))''.

(g) EFFECTIVE DATES.—

(1) IPPS.—The amendments made by subsection (a) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to discharges occurring on or after January 1, 2010.

(2) SNF AND IRF.—The amendments made by subsections (b) and (d) shall apply to annual increases effected for fiscal years beginning with fiscal year 2011.

(3) HOSPICE CARE.—The amendment made by subsection (f) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to days of care occurring on or after January 1, 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG–53 and under the RUG–44 classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year 2010 by the appropriate recalibration factor as proposed in the final rule for Medicare skilled nursing facilities issued by such Secretary on August 11, 2009 (74 Federal Register 40287 et seq.).

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.—

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services shall, under the system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), increase payment by 10 percent for non-therapy ancillary services (as specified by the Secretary in the notice issued on November 27, 1998 (63 Federal Register 65561 et seq.)) and shall decrease payment for the therapy case mix component of such rates by 5.5 percent.

(B) EFFECTIVE DATE.—The changes in payment described in subparagraph (A) shall apply for days on or after April 1, 2010, and until the Secretary implements an alternative case mix classification system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.

(2) CHANGES UNDER A FUTURE SNF CASE MIX CLASSIFICATION SYSTEM.—

(A) ANALYSIS.—

(i) IN GENERAL.—The Secretary of Health and Human Services shall analyze payments for non-therapy ancillary services under a future skilled nursing facility classification system to ensure the accuracy of payment for non-therapy ancillary services. Such analysis shall consider use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay, diagnoses, broad RUG category, and a proxy for length of stay.

(ii) APPLICATION.—Such analysis shall be conducted in a manner such that the future skilled nursing facility classification system is implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(B) CONSULTATION.—In conducting the analysis under subparagraph (A), the Secretary shall consult with interested parties, including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of nontherapy ancillary costs.

(C) RULEMAKING.—The Secretary shall include the result of the analysis under subparagraph (A) in the fiscal year 2011 rulemaking cycle for purposes of implementation beginning for such fiscal year.

(D) IMPLEMENTATION.—Subject to subparagraph (E) and consistent with subparagraph (A)(ii), the Secretary shall implement changes to payments for non-therapy ancillary services (which shall include a separate rate component for non-therapy ancillary services and may include use of a model that predicts payment amounts applicable for non-therapy ancillary services) under such future skilled nursing facility services classification system as the Secretary determines appropriate based on the analysis conducted pursuant to subparagraph (A).

(E) BUDGET NEUTRALITY.—The Secretary shall implement changes described in subparagraph (D) in a manner such that the estimated expenditures under such future skilled nursing facility services classification system for a fiscal year beginning with fiscal year 2011 with such changes would be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under such future skilled nursing facility services classification system for such year without such changes.

(c) OUTLIER POLICY FOR NTA AND THERAPY.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following new paragraph:

''(13) OUTLIERS FOR NTA AND THERAPY.—

''(A) IN GENERAL.—With respect to outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010, the Secretary—

''(i) shall provide for an addition or adjustment to the payment amount otherwise made under this section with respect to nontherapy ancillary services in the case of such outliers; and

''(ii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to therapy services in the case of such outliers.

''(B) OUTLIERS BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

''(C) BUDGET NEUTRALITY.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year may not exceed 2 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.''.

(d) CONFORMING AMENDMENTS.—Section 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' before ''adjustments''; and

(B) by inserting '', and adjustment under section 1111(b) of the Affordable Health Care for America Act'' before the semicolon at the end;

(2) in subparagraph (B), by striking ''and'';

(3) in subparagraph (C), by striking the period and inserting ''; and''; and

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

''(D) the establishment of outliers under paragraph (13).''.

SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain.

(2) COORDINATION WITH MEDICAID DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1704(a).

(b) PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) In lieu of the amount of Medicare DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Social Security Act, the amount of Medicare DSH payment shall be an amount based on the recommendations of the report under subsection (a)(1)(A) and shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size.

(B) Subject to paragraph (3), make an additional payment to a hospital by an amount that is estimated based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

(2) SIGNIFICANT DECREASE IN NATIONAL RATE OF UNINSURANCE AS A RESULT OF THIS ACT.—For purposes of this subsection—

(A) IN GENERAL.—There is a ''significant decrease in the national rate of uninsurance as a result of this Act'' if there is a decrease in the national rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(B) NATIONAL RATE OF UNINSURANCE DEFINED.—The term ''national rate of uninsurance'' means, for a year, such rate for the under-65 population for the year as determined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

(3) UNCOMPENSATED CARE INCREASE.—

(A) COMPUTATION OF DSH SAVINGS.—For each fiscal year (beginning with fiscal year 2017), the Secretary shall estimate the aggregate reduction in the amount of Medicare DSH payment that would be expected to result from the adjustment under paragraph (1)(A).

(B) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall compute the additional payment to a hospital as described in paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the estimated aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care receive a greater increase.

(c) MEDICARE DSH.—In this section, the term ''Medicare DSH'' means adjustments in payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATORIUM.

Section 4301(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) by striking ''October 1, 2009'' and inserting ''October 1, 2010''; and

(2) by striking ''for fiscal year 2009'' and inserting ''for fiscal years 2009 and 2010''.

SEC. 1114. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES AND TO PROVIDE FOR RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (2) in the matter preceding subparagraph (A), is amended by striking ''nurse practitioner or clinical nurse specialist'' and inserting ''nurse practitioner, a clinical nurse specialist, or a physician assistant''.

(2) in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant''.

(b) RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.—

(1) IN GENERAL.—Section 1861(dd)(3)(B) of such Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

(A) by striking ''or nurse'' and inserting '', the nurse''; and

(B) by inserting ''or the physician assistant (as defined in such subsection),'' after ''subsection (aa)(5)),''.

(2) CONFORMING AMENDMENT.—Section 1814(a)(7)(A)(i)(I) of such Act (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''or a physician assistant'' after ''a nurse practitioner''.

(3) CONSTRUCTION.—Nothing in the amendments made by this subsection shall be construed as changing the requirements of section 1842(b)(6)(C) of the Social Security Act (42 U.S.C. 1395u(b)(6)(C)) with respect to payment for services of physician assistants under part B of title XVIII of such Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

''(9) FEEDBACK IMPLEMENTATION PLAN.—

''(A) TIMELINE FOR FEEDBACK PROGRAM.—

''(i) EVALUATION.—During 2011 the Secretary shall conduct the evaluation specified in subparagraph (E)(i).

''(ii) EXPANSION.—The Secretary shall expand the Program under this subsection as specified in subparagraph (E)(ii).

''(B) ESTABLISHMENT OF NATURE OF REPORTS.—

''(i) IN GENERAL.—The Secretary shall develop and specify the nature of the reports that will be disseminated under this subsection, based on results and findings from the Program under this subsection as in existence before the date of the enactment of this paragraph. Such reports may be based on a per capita basis, an episode basis that combines separate but clinically related physicians' services and other items and services furnished or ordered by a physician into an episode of care, as appropriate, or both.

''(ii) TIMELINE FOR DEVELOPMENT.—The nature of the reports described in clause (i) shall be developed by not later than January 1, 2012.

''(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the nature of the reports developed under clause (i) available to the public.

''(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this subsection, establish methodologies as appropriate such as to—

''(i) attribute items and services, in whole or in part, to physicians;

''(ii) identify appropriate physicians for purposes of comparison under subparagraph (B)(i); and

''(iii) aggregate items and services attributed to a physician under clause (i) into a composite measure per individual.

''(D) FEEDBACK PROGRAM.—The Secretary shall engage in efforts to disseminate reports under this subsection. In disseminating such reports, the Secretary shall consider the following:

''(i) Direct meetings between contracted physicians, facilitated by the Secretary, to discuss the contents of reports under this subsection, including any reasons for divergence from local or national averages.

''(ii) Contract with local, non-profit entities engaged in quality improvement efforts at the community level. Such entities shall use the reports under this subsection, or such equivalent tool as specified by the Secretary. Any exchange of data under this paragraph shall be protected by appropriate privacy safeguards.

''(iii) Mailings or other methods of communication that facilitate large-scale dissemination.

''(iv) Other methods specified by the Secretary.

''(E) EVALUATION AND EXPANSION.—

''(i) EVALUATION.—The Secretary shall evaluate the methods specified in subparagraph (D) with regard to their efficacy in changing practice patterns to improve quality and decrease costs.

''(ii) EXPANSION.—Taking into account the cost of each method specified in subparagraph (D), the Secretary shall develop a plan to disseminate reports under this subsection in a significant manner in the regions and cities of the country with the highest utilization of services under this title. To the extent practicable, reports under this subsection shall be disseminated to increasing numbers of physicians each year, such that during 2014 and subsequent years, reports are disseminated at least to physicians with utilization rates among the highest 5 percent of the nation, subject the authority to focus under paragraph (4).

''(F) ADMINISTRATION.—

''(i) Chapter 35 of title 44, United States Code shall not apply to this paragraph.

''(ii) Notwithstanding any other provision of law, the Secretary may implement the provisions of this paragraph by program instruction or otherwise.''.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraphs:

''(K) POTENTIALLY MISVALUED CODES.—

''(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

''(L) VALIDATING RELATIVE VALUE UNITS.—

''(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

''(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

''(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii)

''(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $20,000,000 for fiscal year 2010 and each subsequent fiscal year. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(3) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 1395ee(a)) is repealed.

SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

''(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

''(2) IDENTIFICATION OF EFFICIENT AREAS.—

''(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending under this part and part A for services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to eliminate the effect of geographic adjustments in payment rates.

''(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

''(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

''(i) the identification of a county or other area under subparagraph (A); or

''(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

''(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI).

(a) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

''(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.''.

(b) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ''There shall be'' and inserting ''Except as provided in subparagraph (I), there shall be''; and

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

''(I) INFORMAL APPEALS PROCESS.—By not later than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

(c) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of such Act is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on

quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The development of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) clinical quality of care furnished to an individual.

''(B) The collection of health data to identify deficiencies in the quality and coordination of care for individuals eligible for benefits under this part.

''(C) Such other activities as specified by the Secretary.''.

(d) EXTENSION OF INCENTIVE PAYMENTS.—Section 1848(m)(1) of such Act (42 U.S.C. 1395w–4(m)(1)) is amended—

(1) in subparagraph (A), by striking ''2010'' and inserting ''2012''; and

(2) in subparagraph (B)(ii), by striking ''2009 and 2010'' and inserting ''for each of the years 2009 through 2012''.

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C.1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION TO USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—

''(i) REVISION.—Subject to clause (ii) and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2011, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the Metropolitan Statistical Area (MSA) iterative Geographic Adjustment Factor methodology as follows:

''(I) The Secretary shall configure the physician fee schedule areas using the Metropolitan Statistical Areas (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget and published in the Federal Register, using the most recent available decennial population data as of the date of the enactment of the Affordable Health Care for America Act, as the basis for the fee schedule areas.

''(II) For purposes of this clause, the Secretary shall treat all areas not included in an MSA as a single rest of the State MSA.

''(III) The Secretary shall list all MSAs within the State by Geographic Adjustment Factor described in paragraph (2) (in this paragraph referred to as a 'GAF') in descending order.

''(IV) In the first iteration, the Secretary shall compare the GAF of the highest cost MSA in the State to the weighted-average GAF of all the remaining MSAs in the State (including the rest of State MSA described in subclause (II)). If the ratio of the GAF of the highest cost MSA to the weighted-average of the GAF of remaining lower cost MSAs is 1.05 or greater, the highest cost MSA shall be a separate fee schedule area.

''(V) In the next iteration, the Secretary shall compare the GAF of the MSA with the second-highest GAF to the weighted-average GAF of the all the remaining MSAs (excluding MSAs that become separate fee schedule areas). If the ratio of the second-highest MSA's GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, the second-highest MSA shall be a separate fee schedule area. ''(VI) The iterative process shall continue until the ratio of the GAF of the MSA with highest remaining GAF to the weighted-average of the remaining MSAs with lower GAFS is less than 1.05, and the remaining group of MSAs with lower GAFS shall be treated as a single fee schedule area.

''(VI) For purposes of the iterative process described in this clause, if two MSAs have identical GAFs, they shall be combined.

''(ii) TRANSITION.—For services furnished on or after January 1, 2011, and before January 1, 2016, in the State of California, after calculating the work, practice expense, and malpractice geographic indices that would otherwise be determined under clauses (i), (ii), and (iii) of paragraph (1)(A) for a fee schedule area determined under clause (i), if the index for a county within a fee schedule area is less than the index in effect for such county on December 31, 2010, the Secretary shall instead apply the index in effect for such county on such date.

''(B) SUBSEQUENT REVISIONS.—After the transition described in subparagraph (A)(ii), not less than every 3 years the Secretary shall review and update the fee schedule areas using the methodology described in subparagraph (A)(i) and any updated MSAs as defined by the Director of the Office of Management and Budget and published in the Federal Register. The Secretary shall review and make any changes pursuant to such reviews concurrent with the application of the periodic review of the adjustment factors required under paragraph (1)(C) for California.

''(C) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2011, for the State of California, any reference in this section to a fee schedule area shall be deemed a reference to an MSA in the State (including the single rest of state MSA described in subparagraph (A)(i)(II)).''.

(b) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(C), the term''.

PART 2—MARKET BASKET UPDATES

SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) OUTPATIENT HOSPITALS.—

(1) IN GENERAL.—Section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended——

(A) in the first sentence—

(i) by inserting ''(which is subject to the productivity adjustment described in subclause (II) of such section)'' after ''1886(b)(3)(B)(iii)''; and

(ii) by inserting ''(but not below 0)'' after ''reduced''; and

(B) in the second sentence, by inserting ''and which is subject, beginning with 2010, to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to increase factors for services furnished in years beginning with 2010.

(b) AMBULANCE SERVICES.—Section 1834(l)(3)(B) of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by inserting before the period at the end the following: ''and, in the case of years beginning with 2010, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(c) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of such Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i), for services furnished during 2010 or any subsequent year, to the extent that an annual percentage change factor applies, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(d) LABORATORY SERVICES.—Section 1833(h)(2)(A) of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i), by striking ''for each of the years 2009 through 2013'' and inserting ''for 2009''; and

(2) clause (ii)—

(A) by striking ''and'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(V) the annual adjustment in the fee schedules determined under clause (i) for years beginning with 2010 shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K), by inserting before the semicolon at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'';

(2) in subparagraph (L)(i), by inserting after ''June 2013,'' the following: ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II),'';

(3) in subparagraph (L)(ii), by inserting after ''June 2013'' the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''; and

(4) in subparagraph (M), by inserting before the period at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

PART 3—OTHER PROVISIONS

SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) in the heading, by inserting ''CERTAIN COMPLEX REHABILITATIVE'' after ''OPTION FOR''; and

(2) by striking ''power-driven wheelchair'' and inserting ''complex rehabilitative power-driven wheelchair recognized by the Secretary as classified within group 3 or higher''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1)(B)(i)(I) of such section.

SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DECLINE OWNERSHIP, OF A CERTAIN ITEM OF COMPLEX DURABLE MEDICAL EQUIPMENT AFTER THE 13-MONTH CAPPED RENTAL PERIOD ENDS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (ii)—

(A) by striking ''RENTAL.—On'' and inserting ''RENTAL.—

''(I) IN GENERAL.—Except as provided in subclause (II), on''; and

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

''(II) OPTION TO ACCEPT OR REJECT TRANSFER OF TITLE TO GROUP 3 SUPPORT SURFACE.—

''(aa) IN GENERAL.—During the 10th continuous month during which payment is made for the rental of a Group 3 Support Surface under clause (i), the supplier of such item shall offer the individual the option to accept or reject transfer of title to a Group 3 Support Surface after the 13th continuous

month during which payment is made for the rental of the Group 3 Support Surface under clause (i). Such title shall be transferred to the individual only if the individual notifies the supplier not later than 1 month after the supplier makes such offer that the individual agrees to accept transfer of the title to the Group 3 Support Surface. Unless the individual accepts transfer of title to the Group 3 Support Surface in the manner set forth in this subclause, the individual shall be deemed to have rejected transfer of title. If the individual agrees to accept the transfer of the title to the Group 3 Support Surface, the supplier shall transfer such title to the individual on the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i).

''(bb) SPECIAL RULE.—If, on the effective date of this subclause, an individual's rental period for a Group 3 Support Surface has exceeded 10 continuous months, but the first day that begins after the 13th continuous month during which payment is made for the rental under clause (i) has not been reached, the supplier shall, within 1 month following such effective date, offer the individual the option to accept or reject transfer of title to a Group 3 Support Surface. Such title shall be transferred to the individual only if the individual notifies the supplier not later than 1 month after the supplier makes such offer that the individual agrees to accept transfer of title to the Group 3 Support Surface. Unless the individual accepts transfer of title to the Group 3 Support Surface in the manner set forth in this subclause, the individual shall be deemed to have rejected transfer of title. If the individual agrees to accept the transfer of the title to the Group 3 Support Surface, the supplier shall transfer such title to the individual on the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i) unless that day has passed, in which case the supplier shall transfer such title to the individual not later than 1 month after notification that the individual accepts transfer of title.

''(cc) TREATMENT OF SUBSEQUENT RESUPPLY WITHIN PERIOD OF REASONABLE USEFUL LIFETIME OF GROUP 3 SUPPORT SURFACE IN CASE OF NEED.—If an individual rejects transfer of title to a Group 3 Support Surface under this subclause and the individual requires such Support Surface at any subsequent time during the period of the reasonable useful lifetime of such equipment (as defined by the Secretary) beginning with the first month for which payment is made for the rental of such equipment under clause (i), the supplier shall supply the equipment without charge to the individual or the program under this title during the remainder of such period, other than payment for maintenance and servicing during such period which would otherwise have been paid if the individual had accepted title to such equipment. The previous sentence shall not affect the payment of amounts under this part for such equipment after the end of such period of the reasonable useful lifetime of the equipment.

''(dd) PAYMENTS.—Maintenance and servicing payments shall be made in accordance with clause (iv), in the case of a supplier that transfers title to the Group 3 Support Surface under this subclause, after such transfer and, in the case of an individual who rejects transfer of title under this subclause, after the end of the period of medical need during which payment is made under clause (i).''; and

(2) in clause (iv), by inserting ''or, in the case of an individual who rejects transfer of title to a Group 3 Support Surface under clause (ii), after the end of the period of medical need during which payment is made under clause (i),'' after ''under clause (ii)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to durable medical equipment not later than January 1, 2011.

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking, the first place it appears, ''January 1, 2010'' and inserting ''January 1, 2012''.

SEC. 1143. HOME INFUSION THERAPY REPORT TO CONGRESS.

Not later than July 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran's health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of the scope of services provided by home infusion therapy providers to their patients in such programs.

(2) The benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital and nursing home stays as a result of Medicare coverage of home infusion therapy.

(3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program.

(4) Recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy and their applicability to the Medicare program.

SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS (ASCS) TO SUBMIT COST DATA AND OTHER DATA.

(a) COST REPORTING.—

(1) IN GENERAL.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

''(8) The Secretary shall require, as a condition of the agreement described in section 1832(a)(2)(F)(i), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.''.

(2) DEVELOPMENT OF COST REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop a cost report form for use under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(3) AUDIT REQUIREMENT.—The Secretary shall provide for periodic auditing of cost reports submitted under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(4) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to agreements applicable to cost reporting periods beginning 18 months after the date the Secretary develops the cost report form under paragraph (2).

(b) ADDITIONAL DATA ON QUALITY.—

(1) IN GENERAL.—Section 1833(i)(7) of such Act (42 U.S.C. 1395l(i)(7)) is amended—

(A) in subparagraph (B), by inserting ''subject to subparagraph (C),'' after ''may otherwise provide,''; and

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

''(C) Under subparagraph (B) the Secretary shall require the reporting of such additional data relating to quality of services furnished in an ambulatory surgical facility, including data on health care associated infections, as the Secretary may specify.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall to reporting for years beginning with 2012.

SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 1146. PAYMENT FOR IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT A PRESUMED LEVEL OF UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT A PRESUMED LEVEL OF UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2011, the Secretary shall adjust such number of units so it reflects a presumed rate of utilization of imaging equipment of 75 percent.''; and

(2) in subsection (c)(2)(B)(v)), by adding at the end the following new subclause:

''(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the presumed utilization of 75 percent under subsection (b)(4)(C) instead of a presumed utilization of imaging equipment of 50 percent.''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of such Act (42 U.S.C. 1395w–4) is further amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after January 1, 2011, the Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part

405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

''(III) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 percent to 50 percent as described in subsection (b)(4)(D).''.

SEC. 1147. DURABLE MEDICAL EQUIPMENT PROGRAM IMPROVEMENTS.

(a) WAIVER OF SURETY BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended by adding at the end the following sentence: ''The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy or supplier that exclusively furnishes eyeglasses or contact lenses described in section 1861(s)(8) if the pharmacy or supply has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued (which may include renewal of) a supplier number (as described in the first sentence of this paragraph) for at least 5 years, and if a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed for such pharmacy or supplier.''.

(b) ENSURING SUPPLY OF OXYGEN EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in clause (ii), by striking ''After the'' and inserting ''Except as provided in clause (iii), after the''; and

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

''(iii) CONTINUATION OF SUPPLY.—In the case of a supplier furnishing such equipment to an individual under this subsection as of the 27th month of the 36 months described in clause (i), the supplier furnishing such equipment as of such month shall continue to furnish such equipment to such individual (either directly or though arrangements with other suppliers of such equipment) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier has accepted responsibility for continuing to furnish such equipment during the remainder of such period.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as of the date of the enactment of this Act and shall apply to the furnishing of equipment to individuals for whom the 27th month of a continuous period of use of oxygen equipment described in section 1834(a)(5)(F) of the Social Security Act occurs on or after July 1, 2010.

(c) TREATMENT OF CURRENT ACCREDITATION APPLICATIONS.—Section 1834(a)(20)(F) of such Act (42 U.S.C. 1395m(a)(20)(F)) is amended—

(1) in clause (i)—

(A) by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)''; and

(B) by striking ''and'' at the end;

(2) by striking the period at the end of clause (ii)(II) and by inserting a semicolon;

(3) by inserting after clause (ii) the following new clauses:

''(iii) the requirement for accreditation described in clause (i) shall not apply for purposes of supplying diabetic testing supplies, canes, and crutches in the case of a pharmacy that is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies; and

''(iv) a supplier that has submitted an application for accreditation before August 1, 2009, shall retain the supplier's provider or supplier number until an independent accreditation organization determines if such supplier complies with requirements under this paragraph.''; and

(4) by adding at the end the following new sentence: ''Nothing in clauses (iii) and (iv) shall be construed as affecting the application of an accreditation requirement for suppliers to qualify for bidding in a competitive acquisition area under section 1847,''.

(d) RESTORING 36-MONTH OXYGEN RENTAL PERIOD IN CASE OF SUPPLIER BANKRUPTCY FOR CERTAIN INDIVIDUALS.—Section 1834(a)(5)(F) of such Act (42 U.S.C. 1395m(a)(5)(F)), as amended by subsection (b), is further amended by adding at the end the following new clause:

''(iv) EXCEPTION FOR BANKRUPTCY.—If a supplier who furnishes oxygen and oxygen equipment to an individual is declared bankrupt and its assets are liquidated and at the time of such declaration and liquidation more than 24 months of rental payments have been made, such individual may begin a new 36-month rental period under this subparagraph with another supplier of oxygen.''.

SEC. 1148. MEDPAC STUDY AND REPORT ON BONE MASS MEASUREMENT.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study shall focus on the following:

(1) An assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs.

(2) The impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically.

(3) A review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compares to such recommendations.

(4) In conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries.

(b) REPORT.—The Commission shall submit a report to the Congress, not later than 9 months after the date of the enactment of this Act, containing a description of the results of the study conducted under subsection (a) and the conclusions and recommendations, if any, regarding each of the issues described in paragraphs (1), (2) (3) and (4) of such subsection.

SEC. 1149. TIMELY ACCESS TO POST-MASTECTOMY ITEMS.

(a) IN GENERAL.—Section 1834(h)(1) of the Social Security Act (42 U.S.C. 1395m) is amended—

(1) by redesignating subparagraph (H) as subparagraph (I); and

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

''(H) SPECIAL PAYMENT RULE FOR POST-MASTECTOMY EXTERNAL BREAST PROSTHESIS GARMENTS.—Payment for post-mastectomy external breast prosthesis garments shall be made regardless of whether such items are supplied to the beneficiary prior to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary shall develop policies to ensure appropriate beneficiary access and utilization safeguards for such items supplied to a beneficiary prior to the mastectomy or other breast cancer surgical procedure.''

(b) EFFECTIVE DATE.—This amendment shall apply not later than January 1, 2011.

SEC. 1149A. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A), by striking ''or'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case of one or more interchangeable biological products (as defined in subsection (c)(6)(I)) and their reference biological product (as defined in subsection (c)(6)(J)), which shall be included in the same billing and payment code, the sum of—

''(i) the average sales price as determined using the methodology described in paragraph (6) applied to such interchangeable and reference products for all National Drug Codes assigned to such products in the same manner as such paragraph (6) is applied to multiple source drugs; and

''(ii) 6 percent of the amount determined under clause (i);

''(D) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the sum of—

''(i) the average sales price as determined using the methodology described in paragraph (4) applied to such biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph (4) is applied to a single source drug; and

''(ii) 6 percent of the amount determined under paragraph (4) or the amount determined under subparagraph (C)(ii), as the case may be, for the reference biological product (as defined in subsection (c)(6)(J)); or

''(E) in the case of a reference biological product for both an interchangeable biological product and a biosimilar product, the amount determined in subparagraph (C).''; and

(2) in subsection (c)(6)—

(A) by amending subparagraph (D)(i) to read as follows:

''(i) a biological, including a reference biological product for a biosimilar product, but excluding—

''(I) a biosimilar biological product;

''(II) an interchangeable biological product;

''(III) a reference biological product for an interchangeable biological product; and

''(IV) a reference biological product for both an interchangeable biological product and a biosimilar product; or''; and

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

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product licensed as a biosimilar biological product under section 351(k) of the Public Health Service Act.

''(I) INTERCHANGEABLE BIOLOGICAL PRODUCT.—The term 'interchangeable biological product' means a biological product licensed as an interchangeable biological product under section 351(k) of the Public Health Service Act

''(J) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product that is referred to in the application for a biosimilar or interchangeable biological product licensed under section 351(k) of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products,

interchangeable biological products, and reference biological products beginning with the first day of the second calendar quarter after the date of the enactment of this Act.

SEC. 1149B. STUDY AND REPORT ON DME COMPETITIVE BIDDING PROCESS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the potential establishment of a program under Medicare under title XVIII of the Social Security Act to acquire durable medical equipment and supplies through a competitive bidding process among manufacturers of such equipment and supplies. Such study shall address the following:

(1) Identification of types of durable medical equipment and supplies that would be appropriate for bidding under such a program.

(2) Recommendations on how to structure such an acquisition program in order to promote fiscal responsibility while also ensuring beneficiary access to high quality equipment and supplies.

(3) Recommendations on how such a program could be phased-in and on what geographic level would bidding be most appropriate.

(4) In addition to price, recommendations on criteria that could be factored into the bidding process.

(5) Recommendations on how suppliers could be compensated for furnishing and servicing equipment and supplies acquired under such a program.

(6) Comparison of such a program to the current competitive bidding program under Medicare for durable medical equipment, as well as any other similar Federal acquisition programs, such as the General Services Administration's vehicle purchasing program.

(7) Any other consideration relevant to the acquisition, supply, and service of durable medical equipment and supplies that is deemed appropriate by the Comptroller General.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the findings of the study under subsection (a).

Subtitle C—Provisions Related to Medicare Parts A and B

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS.

(a) HOSPITALS.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EXCESS READMISSIONS.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year, the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

''(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(3) ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

''(ii) the floor adjustment factor specified in subparagraph (C).

''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

''(i) fiscal year 2012 is 0.99;

''(ii) fiscal year 2013 is 0.98;

''(iii) fiscal year 2014 is 0.97; or

''(iv) a subsequent fiscal year is 0.95.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for a fiscal year, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

''(i) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

''(ii) the number of admissions for such condition for such hospital for such fiscal year; and

''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for the applicable period for such fiscal year minus 1.

''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for a fiscal year, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such fiscal year.

''(C) EXCESS READMISSION RATIO.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

''(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under subparagraph (C) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 50th percentile.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

''(ii) measures of such readmissions—

''(I) have been endorsed by the entity with a contract under section 1890(a); and

''(II) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

''(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3).

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the determination of base operating DRG payment amounts;

''(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges

under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5);

''(C) the measures of readmissions as described in paragraph (5)(A)(ii); and

''(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in payment under paragraph (8)(B)(ii), the aggregate cap under paragraph (8)(C)(i), the hospital-specific limit under paragraph (8)(C)(ii), and the form of payment made by the Secretary under paragraph (8)(D).

''(7) MONITORING INAPPROPRIATE CHANGES IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine if such hospitals have taken steps to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions or taken other inappropriate steps involving readmissions or transfers. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction.

''(8) ASSISTANCE TO CERTAIN HOSPITALS.—

''(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps described in subparagraph (E) to address factors that may impact readmissions of individuals who are discharged from such a hospital, for fiscal years beginning on or after October 1, 2011, the Secretary shall make a payment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C). The Secretary shall provide priority to hospitals that serve Medicare beneficiaries at highest risk for readmission or for a poor transition from such a hospital to a post-hospital site of care.

''(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

''(i) had (or, in the case of an 1814(b)(3) hospital, otherwise would have had) a disproportionate patient percentage (as defined in section 1886(d)(5)(F)) of at least 30 percent, using the latest available data as estimated by the Secretary; and

''(ii) provides assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E).

''(C) CAPS.—

''(i) AGGREGATE CAP.—The aggregate amount of the payment adjustment under this paragraph for a fiscal year shall not exceed 5 percent of the estimated difference in the spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

''(ii) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed the estimated difference in spending that would occur for such fiscal year for such hospital with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

''(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise.

''(E) USE OF ADDITIONAL PAYMENT.—

''(i) IN GENERAL.—Funding under this paragraph shall be used by targeted hospitals for activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, including transitional care services described in clause (ii) and any or all of the other activities described in clause (iii).

''(ii) TRANSITIONAL CARE SERVICES.—The transitional care services described in this clause are transitional care services furnished by a qualified transitional care provider, such as a nurse or other health professional, who meets relevant experience and training requirements as specified by the Secretary that support a beneficiary under this section beginning on the date of an individual's admission to a hospital for inpatient hospital services and ending at the latest on the last day of the 90-day period beginning on the date of the individual's discharge from the applicable hospital. The Secretary shall determine and update services to be included in transitional care services under this clause as appropriate, based on evidence of their effectiveness in reducing hospital readmissions and improving health outcomes. Such services shall include the following:

''(I) Conduct of an assessment prior to discharge, which assessment may include an assessment of the individual's physical and mental condition, cognitive and functional capacities, medication regimen and adherence, social and environmental needs, and primary caregiver needs and resources.

''(II) Development of a evidence-based plan of transitional care for the individual developed after consultation with the individual and the individual's primary caregiver and other health team members, as appropriate. Such plan shall include a list of current therapies prescribed, treatment goals and may include other items or elements as determined by the Secretary, such as identifying list of potential health risks and future services for both the individual and any primary caregiver.

''(iii) OTHER ACTIVITIES.—The other activities described in this clause are the following:

''(I) Providing other care coordination services not described under clause (ii).

''(II) Hiring translators and interpreters.

''(III) Increasing services offered by discharge planners.

''(IV) Ensuring that individuals receive a summary of care and medication orders upon discharge.

''(V) Developing a quality improvement plan to assess and remedy preventable readmission rates.

''(VI) Assigning appropriate follow-up care for discharged individuals.

''(VII) Doing other activities as determined appropriate by the Secretary.

''(F) GAO REPORT ON USE OF FUNDS.—Not later than 3 years after the date on which funds are first made available under this paragraph, the Comptroller General of the United States shall submit to Congress a report on the use of such funds. Such report shall consider information on the effective uses of such funds, how the uses of such funds affected hospital readmission rates (including at 6 months post-discharge), health outcomes and quality, reductions in expenditures under this title and the experiences of beneficiaries, primary caregivers, and providers, as well as any appropriate recommendations.''.

(b) APPLICATION TO CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended—

(1) in paragraph (5)—

(A) by striking ''and'' at the end of subparagraph (C);

(B) by striking the period at the end of subparagraph (D) and inserting ''; and'';

(C) by inserting at the end the following new subparagraph:

''(E) the methodology for determining the adjustment factor under paragraph (5), including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmissions.''; and

(D) by redesignating such paragraph as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) The adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection) in a manner similar to the manner in which such section applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2).''.

(c) POST ACUTE CARE PROVIDERS.—

(1) INTERIM POLICY.—

(A) IN GENERAL.—With respect to a readmission to an applicable hospital or a critical access hospital (as described in section 1814(l) of the Social Security Act) from a post acute care provider (as defined in paragraph (3)) and such a readmission is not governed by section 412.531 of title 42, Code of Federal Regulations, if the claim submitted by such a post-acute care provider under title XVIII of the Social Security Act indicates that the individual was readmitted to a hospital from such a post-acute care provider or admitted from home and under the care of a home health agency within 30 days of an initial discharge from an applicable hospital or critical access hospital, the payment under such title on such claim shall be the applicable percent specified in subparagraph (B) of the payment that would otherwise be made under the respective payment system under such title for such post-acute care provider if this subsection did not apply. In applying the previous sentence, the Secretary shall exclude a period of 1 day from the date the individual is first admitted to or under the care of the post-acute care provider.

(B) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (A), the applicable percent is—

(i) for fiscal or rate year 2012 is 0.996;

(ii) for fiscal or rate year 2013 is 0.993; and

(iii) for fiscal or rate year 2014 is 0.99.

(C) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished (as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal year or rate year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

(2) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall develop appropriate measures of readmission rates for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act but may adopt and apply such measures under this paragraph without such an endorsement. The Secretary shall expand such measures in a manner similar to the manner in which applicable conditions are expanded under paragraph (5)(B) of section 1886(p) of the Social Security Act, as added by subsection (a).

(B) IMPLEMENTATION.—The Secretary shall apply, on or after October 1, 2014, with respect to post acute care providers, policies similar to the policies applied with respect to applicable hospitals and critical access hospitals under the amendments made by subsection (a). The provisions of paragraph (1) shall apply with respect to any period on or after October 1, 2014, and before such application date described in the previous sentence in the same manner as such provisions apply with respect to fiscal or rate year 2014.

(C) MONITORING AND PENALTIES.—The provisions of paragraph (7) of such section 1886(p) shall apply to providers under this paragraph

in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term ''post acute care provider'' means—

(i) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (described in section 1886(h)(1)(A) of such Act);

(iii) a home health agency (as defined in section 1861(o) of such Act); and

(iv) a long term care hospital (as defined in section 1861(ccc) of such Act).

(B) OTHER TERMS.—The terms ''applicable condition'', ''applicable hospital'', and ''readmission'' have the meanings given such terms in section 1886(p)(5) of the Social Security Act, as added by subsection (a)(1).

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider approaches such as—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act (in a budget neutral manner) for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or critical access hospital;

(B) developing measures of rates of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physicians.

(3) REPORT.—The Secretary shall issue a public report on such study not later than the date that is one year after the date of the enactment of this Act.

(e) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning with 2010. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM PLAN AND BUNDLING PILOT PROGRAM.

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a detailed plan to reform payment for post acute care (PAC) services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the ''Medicare program)''. The goals of such payment reform are to—

(A) improve the coordination, quality, and efficiency of such services; and

(B) improve outcomes for individuals such as reducing the need for readmission to hospitals from providers of such services.

(2) BUNDLING POST ACUTE SERVICES.—The plan described in paragraph (1) shall include detailed specifications for a bundled payment for post acute services (in this section referred to as the ''post acute care bundle''), and may include other approaches determined appropriate by the Secretary.

(3) POST ACUTE SERVICES.—For purposes of this section, the term ''post acute services'' means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, hospital based outpatient rehabilitation facilities and home health agencies to an individual after discharge of such individual from a hospital, and such other services determined appropriate by the Secretary.

(b) DETAILS.—The plan described in subsection (a)(1) shall include consideration of the following issues:

(1) The nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and the period covered by the bundle.

(2) Whether the payment should be consolidated with the payment under the inpatient prospective system under section 1886 of the Social Security Act (in this section referred to as MS–DRGs) or a separate payment should be established for such bundle, and if a separate payment is established, whether it should be made only upon use of post acute care services or for every discharge.

(3) Whether the bundle should be applied across all categories of providers of inpatient services (including critical access hospitals) and post acute care services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS–DRGs.

(4) The extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to be achieved with a bundle payment, whether such rates should be established on a national basis or for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences in wages or other appropriate adjustments, and how to update such rates.

(5) The nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed as determined by an appropriate assessment instrument, are offered choice of provider, and the extent to which transitional care services would improve quality of care for individuals and the functioning of a bundled post-acute system.

(6) The nature of relationships that may be required between hospitals and providers of post acute care services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws.

(7) Quality measures that would be appropriate for reporting by hospitals and post acute providers (such as measures that assess changes in functional status and quality measures appropriate for each type of post acute services provider including how the reporting of such quality measures could be coordinated with other reporting of such quality measures by such providers otherwise required).

(8) How cost-sharing for a post acute care bundle should be treated relative to current rules for cost-sharing for inpatient hospital, home health, skilled nursing facility, and other services.

(9) How other programmatic issues should be treated in a post acute care bundle, including rules specific to various types of post-acute providers such as the post-acute transfer policy, three-day hospital stay to qualify for services furnished by skilled nursing facilities, and the coordination of payments and care under the Medicare program and the Medicaid program.

(10) Such other issues as the Secretary deems appropriate.

(c) CONSULTATIONS AND ANALYSIS.—

(1) CONSULTATION WITH STAKEHOLDERS.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies and demonstrations that the Secretary determines appropriate.

(2) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians;

(C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop such plan required in this section; and

(D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Deficit Reduction Act of 2005.

(d) ADMINISTRATION.—

(1) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $15,000,000 for each of the fiscal years 2010 through 2012. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) EXPEDITED DATA COLLECTION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(e) PUBLIC REPORTS.—

(1) INTERIM REPORTS.—The Secretary shall issue interim public reports on a periodic basis on the plan described in subsection (a)(1), the issues described in subsection (b), and impact analyses as the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than the date that is 3 years after the date of the enactment of this Act, the Secretary shall issue a final public report on such plan, including analysis of issues described in subsection (b) and impact analyses.

(f) CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act is amended by inserting after section 1866C the following new section:

''CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES

''SEC. 1866D. (a) CONVERSION AND EXPANSION.—

''(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient, coordinated, and high quality delivery of care—

''(A) convert the acute care episode demonstration program conducted under section 1866C to a pilot program; and

''(B) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.

''(2) BUNDLED PAYMENT STRUCTURES.—

''(A) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

''(i) hospitals and physicians;

''(ii) hospitals and post-acute care providers;

''(iii) hospitals, physicians, and post-acute care providers; or

''(iv) combinations of post-acute providers.

''(B) FURTHER APPLICATION.—

''(i) IN GENERAL.—In carrying out paragraph (1), the Secretary shall apply bundled payments in a manner so as to include collaborative care networks and continuing care hospitals.

''(ii) COLLABORATIVE CARE NETWORK DEFINED.—For purposes of this subparagraph, the term 'collaborative care network' means a consortium of health care providers that provides a comprehensive range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality and efficiency of care, increase preventive services, and promote adherence to post-acute and follow-up care plans.

''(iii) CONTINUING CARE HOSPITAL DEFINED.—For purposes of this subparagraph, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long-term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).

''(b) SCOPE.—The Secretary shall set specific goals for the number of acute and post-acute bundling test sites under the pilot program to ensure that over time the pilot program is of sufficient size and scope to—

''(1) test the approaches under the pilot program in a variety of settings, including urban, rural, and underserved areas;

''(2) include geographic areas and additional conditions that account for significant program spending, as defined by the Secretary; and

''(3) subject to subsection (d), disseminate the pilot program rapidly on a national basis.

To the extent that the Secretary finds inpatient and post acute care bundling to be successful in improving quality and reducing costs, the Secretary shall implement such mechanisms and reforms under the pilot program on as large a geographic scale as practical and economical, consistent with subsection (e). Nothing in this subsection shall be construed as limiting the number of hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program.

''(c) LIMITATION.—The Secretary shall only expand the pilot program under subsection (a) if the Secretary finds that—

''(1) the demonstration program under section 1866C and pilot program under this section maintain or increase the quality of care received by individuals enrolled under this title; and

''(2) such demonstration program and pilot program reduce program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

''(d) CERTIFICATION.—For purposes of subsection (c), the Chief Actuary of the Centers for Medicare & Medicaid Services shall certify whether expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

''(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.

''(f) EVALUATION ON COST AND QUALITY OF CARE.—The Secretary shall conduct an evaluation of the pilot program under subsection (a) to study the effect of such program on costs and quality of care. The findings of such evaluation shall be included in the final report required under section 1152(e)(2) of the Affordable Health Care for America Act.

''(g) STUDY OF ADDITIONAL BUNDLING AND EPISODE-BASED PAYMENT FOR PHYSICIANS' SERVICES.—

''(1) IN GENERAL.—The Secretary shall provide for a study of and development of a plan for testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital services or services rendered in physicians' offices, other than those provided under the pilot program.

''(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.''.

(2) CONFORMING AMENDMENT.—Section 1866C(b) of the Social Security Act (42 U.S.C. 1395cc–3(b)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1866D, the Secretary''.

SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV), by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

''(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;

''(VI) 2010, subject to clause (v), 0 percent; and''.

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iv), by striking ''Insofar as'' and inserting ''Subject to clause (vi), insofar as''; and

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

''(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—

''(I) IN GENERAL.—With respect to the case mix adjustments established in section 484.220(a) of title 42, Code of Federal Regulations, the Secretary shall apply, in 2010, the adjustment established in paragraph (3) of such section for 2011, in addition to applying the adjustment established in paragraph (2) for 2010.

''(II) CONSTRUCTION.—Nothing in this clause shall be construed as limiting the amount of adjustment for case mix for 2010 or 2011 if more recent data indicate an appropriate adjustment that is greater than the amount established in the section described in subclause (I).''.

(b) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (III), by inserting ''and before 2011'' after ''after the period described in subclause (II)''; and

(B) by inserting after subclause (III) the following new subclauses:

''(IV) Subject to clause (iii)(I), for 2011, such amount (or amounts) shall be adjusted by a uniform percentage determined to be appropriate by the Secretary based on analysis of factors such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant.

''(V) Subject to clause (iii)(II), for a year after 2011, such a amount (or amounts) shall be equal to the amount (or amounts) determined under this clause for the previous year, updated under subparagraph (B).''; and

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

''(iii) SPECIAL RULE IN CASE OF INABILITY TO EFFECT TIMELY REBASING.—

''(I) APPLICATION OF PROXY AMOUNT FOR 2011.—If the Secretary is not able to compute the amount (or amounts) under clause (i)(IV) so as to permit, on a timely basis, the application of such clause for 2011, the Secretary shall substitute for such amount (or amounts) 95 percent of the amount (or amounts) that would otherwise be specified under clause (i)(III) if it applied for 2011.

''(II) ADJUSTMENT FOR SUBSEQUENT YEARS BASED ON DATA.—If the Secretary applies subclause (I), the Secretary before July 1, 2011, shall compare the amount (or amounts) applied under such subclause with the amount (or amounts) that should have been applied under clause (i)(IV). The Secretary shall decrease or increase the prospective payment amount (or amounts) under clause (i)(V) for 2012 (or, at the Secretary's discretion, over a period of several years beginning with 2012) by the amount (if any) by which the amount (or amounts) applied under subclause (I) is greater or less, respectively, than the amount (or amounts) that should have been applied under clause (i)(IV).''.

SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATE FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iii), by inserting ''(including being subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))'' after ''in the same manner''; and

(2) in clause (v)(I), by inserting ''(but not below 0)'' after ''reduced''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to home health market basket percentage increases for years beginning with 2011.

SEC. 1155A. MEDPAC STUDY ON VARIATION IN HOME HEALTH MARGINS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding variation in performance of home health agencies in an effort to explain variation in Medicare margins for such agencies. Such study shall include an examination of at least the following issues:

(1) The demographic characteristics of individuals served and the geographic distribution associated with transportation costs.

(2) The characteristics of such agencies, such as whether such agencies operate 24 hours each day, provide charity care, or are part of an integrated health system.

(3) The socio-economic status of individuals served, such as the proportion of such individuals who are dually eligible for Medicare and Medicaid benefits.

(4) The presence of severe and or chronic disease or disability in individuals served, as evidenced by multiple discontinuous home health episodes with a high number of visits per episode.

(5) The differences in services provided, such as therapy and non-therapy services.

(b) REPORT.—Not later than June 1, 2011, the Commission shall submit a report to the Congress on the results of the study conducted under subsection (a) and shall include

in the report the Commission's conclusions and recommendations, if appropriate, regarding each of the issues described in paragraphs (1), (2) and (3) of such subsection.

SEC. 1155B. PERMITTING HOME HEALTH AGENCIES TO ASSIGN THE MOST APPROPRIATE SKILLED SERVICE TO MAKE THE INITIAL ASSESSMENT VISIT UNDER A MEDICARE HOME HEALTH PLAN OF CARE FOR REHABILITATION CASES.

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

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

SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1).'';

(3) by amending subsection (f) to read as follows:

''(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

''(1) IN GENERAL.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

''(A) the covered items and services provided by the entity, and

''(B) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

''(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (i)(1), the hospital shall—

''(A) submit to the Secretary an initial report, and periodic updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

''(B) require that any referring physician owner or investor discloses to the individual being referred, by a time that permits the individual to make a meaningful decision regarding the receipt of services, as determined by the Secretary, the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(C) disclose the fact that the hospital is partially or wholly owned by one or more physicians or has one or more physician investors—

''(i) on any public website for the hospital; and

''(ii) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health services furnished outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

''(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.'';

(4) by amending subsection (g)(5) to read as follows:

''(5) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

''(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

''(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (f)(2)(B) or a hospital that is required, but fails, to meet a disclosure requirement of subsection (f)(2)(C) is subject to a civil money penalty of not more than $10,000 for each case in which disclosure is required to have been made.

''(C) APPLICATION.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''; and

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

''(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on January 1, 2009; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (2), the number of operating rooms, procedure rooms, or beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms, procedure rooms, or beds, respectively, as of such date.

''(D) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

''(i) Any ownership or investment interests that the hospital offers to a physician are not offered on more favorable terms than the terms offered to a person who is not in a position to refer patients or otherwise generate business for the hospital.

''(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

''(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(v) The investment interest of the owner or investor is directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to a person that is not a physician owner or investor.

''(viii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(E) PATIENT SAFETY.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to—

''(i) provide assessment and initial treatment for medical emergencies; and

''(ii) if the hospital lacks additional capabilities required to treat the emergency involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

''(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which a hospital may apply for an exception from the requirement under paragraph (1)(C).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide persons and entities in the community in

which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

''(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i). The Secretary may issue such regulations as interim final regulations.

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, or beds of a hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, or beds' means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, or beds of a hospital pursuant to this paragraph may only occur in facilities on the main campus of the hospital.

''(E) CONDITIONS FOR APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital described in subparagraph (F) or a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is estimated to be less than the national average bed capacity;

''(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

''(vi) that meets other conditions as determined by the Secretary.

''(F) SPECIAL RULE FOR A HIGH MEDICAID FACILITY.—A hospital described in this subparagraph is a hospital that—

''(i) with respect to each of the 3 most recent cost reporting periods for which data are available, has an annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX that is determined by the Secretary to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and

''(ii) meets the conditions described in clauses (iii) and (vi) of subparagraph (E).

''(G) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished).

''(H) PUBLICATION OF FINAL DECISIONS.—Not later than 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Internet website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

''(I) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the exception process under this paragraph, including the establishment of such process, and any determination made under such process.

''(3) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection and subsection (f)(2), the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(4) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits a patient and does not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

''(A) the hospital shall disclose such fact to the patient; and

''(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

''(5) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital's provider agreement if the hospital is not in compliance with regulations pursuant to section 1866.''.

(b) VERIFYING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to verify compliance with the requirements described in subsections (i)(1) and (i)(4) of section 1877 of the Social Security Act, as added by subsection (a)(5). The Secretary may use unannounced site reviews of hospitals and audits to verify compliance with such requirements.

(c) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the amendments made by subsection (a) and the provisions of subsection (b), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account $5,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the amendments made by subsection (a) and the provisions of subsection (b).

SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC ADJUSTMENT FACTORS UNDER MEDICARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academy of Science to conduct a comprehensive empirical study, and provide recommendations as appropriate, on the accuracy of the geographic adjustment factors established under sections 1848(e) and 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)).

(b) MATTERS INCLUDED.—Such study shall include an evaluation and assessment of the following with respect to such adjustment factors:

(1) Empirical validity of the adjustment factors.

(2) Methodology used to determine the adjustment factors.

(3) Measures used for the adjustment factors, taking into account—

(A) timeliness of data and frequency of revisions to such data;

(B) sources of data and the degree to which such data are representative of costs; and

(C) operational costs of providers who participate in Medicare.

(c) EVALUATION.—Such study shall, within the context of the United States health care marketplace, evaluate and consider the following:

(1) The effect of the adjustment factors on the level and distribution of the health care workforce and resources, including—

(A) recruitment and retention that takes into account workforce mobility between urban and rural areas;

(B) ability of hospitals and other facilities to maintain an adequate and skilled workforce; and

(C) patient access to providers and needed medical technologies.

(2) The effect of the adjustment factors on population health and quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(d) REPORT.—The contract under subsection (a) shall provide for the Institute of Medicine to submit, not later than 1 year after the date of the enactment of this Act, to the Secretary and the Congress a report containing results and recommendations of the study conducted under this section.

(e) FUNDING.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO ADDRESS GEOGRAPHIC INEQUITIES.

(a) REVISION OF MEDICARE PAYMENT SYSTEMS.—Taking into account the recommendations described in the report under section 1157, and notwithstanding the geographic adjustments that would otherwise apply under section 1848(e) and section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)), the Secretary of Health and Human Services shall include in proposed rules applicable to the rulemaking cycle for payment systems for physicians' services and inpatient hospital services under sections 1848 and section 1886(d) of such Act, respectively, proposals (as the Secretary determines to be appropriate) to revise the geographic adjustment factors used in such systems. Such proposals'

rules shall be contained in the next rulemaking cycle following the submission to the Secretary of the report described in section 1157.

(b) PAYMENT ADJUSTMENTS.—

(1) FUNDING FOR IMPROVEMENTS.—For years before 2014, the Secretary shall ensure that the additional expenditures resulting from the implementation of the provisions of this section, as estimated by the Secretary, do not exceed $8,000,000,000, and do not exceed half of such amount in any payment year.

(2) HOLD HARMLESS.—In carrying out this subsection—

(A) for payment years before 2014, the Secretary shall not reduce the geographic adjustment below the factor that applied for such payment system in the payment year before such changes; and

(B) for payment years beginning with 2014, the Secretary shall implement the geographic adjustment in a manner that does not result in any net change in aggregate expenditures under title XVIII of the Social Security Act from the amount of such expenditures that the Secretary estimates would have occurred if no geographic adjustment had occurred under this section.

(c) MEDICARE IMPROVEMENT FUND.—

(1) Amounts in the Medicare Improvement Fund under section 1898 of the Social Security Act, as amended by paragraph (2), shall be available to the Secretary to make changes to the geographic adjustments factors as described in subsections (a) and (b) with respect to services furnished before January 1, 2014. No more than one-half of such amounts shall be available with respect to services furnished in any one payment year.

(2) Section 1898(b) of the Social Security Act (42 U.S.C. 1395iii(b)) is amended—

(A) by amending paragraph (1)(A) to read as follows:

''(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and''; and

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

''(5) ADJUSTMENT FOR UNDERFUNDING.—For fiscal year 2014 or a subsequent fiscal year specified by the Secretary, the amount available to the fund under subsection (a) shall be increased by the Secretary's estimate of the amount (based on data on actual expenditures) by which—

''(A) the additional expenditures resulting from the implementation of subsection (a) of section 1158 of the Affordable Health Care for America Act for the period before fiscal year 2014, is less than

''(B) the maximum amount of funds available under subsection (a) of such section for funding for such expenditures.''.

SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section and the succeeding section referred to as the ''Secretary'') shall enter into an agreement with the Institute of Medicine of the National Academies (referred to in this section as the ''Institute'') to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. Such study may draw on recent relevant reports of the Institute and shall include each of the following:

(1) An evaluation of the extent and range of such variation using various units of geographic measurement, including micro areas within larger areas.

(2) An evaluation of the extent to which geographic variation can be attributed to differences in input prices; health status; practice patterns; access to medical services; supply of medical services; socio-economic factors, including race, ethnicity, gender, age, income and educational status; and provider and payer organizational models.

(3) An evaluation of the extent to which variations in spending are correlated with patient access to care, insurance status, distribution of health care resources, health care outcomes, and consensus-based measures of health care quality.

(4) An evaluation of the extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary treatment decisions are made that could be characterized as different from the best available medical evidence.

(5) An evaluation of the extent to which variation can be attributed to patient preferences and patient compliance with treatment protocols.

(6) An assessment of the degree to which variation cannot be explained by empirical evidence.

(7) For Medicare beneficiaries, An evaluation of the extent to which variations in spending are correlated with insurance status prior to enrollment in the Medicare program under title XVIII of the Social Security Act, and institutionalization status; whether beneficiaries are dually eligible for the Medicare program and Medicaid under title XIX of such Act; and whether beneficiaries are enrolled in fee-for-service Medicare or Medicare Advantage.

(8) An evaluation of such other factors as the Institute deems appropriate.

The Institute shall conduct public hearings and provide an opportunity for comments prior to completion of the reports under subsection (e).

(b) RECOMMENDATIONS.—Taking into account the findings under subsection (a) and the changes to the payment systems made by this Act, the Institute shall recommend changes to payment for items and services under parts A and B of title XVIII of the Social Security Act, for addressing variation in Medicare per capita spending for items and services (not including add-ons for graduate medical education, disproportionate share payments, and health information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of such Act) by promoting high-value care (as defined in subsection (f)), with particular attention to high-volume, high-cost conditions. In making such recommendations, the Institute shall consider each of the following:

(1) Measurement and reporting on quality and population health.

(2) Reducing fragmented and duplicative care.

(3) Promoting the practice of evidence-based medicine.

(4) Empowering patients to make value-based care decisions.

(5) Leveraging the use of health information technology.

(6) The role of financial and other incentives affecting provision of care.

(7) Variation in input costs.

(8) The characteristics of the patient population, including socio-economic factors (including race, ethnicity, gender, age, income and educational status), and whether the beneficiaries are dually eligible for the Medicare program under title XVIII of the Social Security Act and Medicaid under title XIX of such Act.

(9) Other topics the Institute deems appropriate.

In making such recommendations, the Institute shall consider an appropriate phase-in that takes into account the impact of payment changes on providers and facilities and preserves access to care for Medicare beneficiaries.

(c) SPECIFIC CONSIDERATIONS.—In making the recommendations under subsection (b), the Institute shall specifically address whether payment systems under title XVIII of the Social Security Act for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the Institute shall consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute finds that application of such a value index would significantly incentivize providers to furnish high-value care, it shall make specific recommendations on how such an index would be designed and implemented. In so doing, it should identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how payments and spending under such title would be affected by such an index.

(d) ADDITIONAL CONSIDERATIONS.—The Institute shall consider the experience of governmental and community-based programs that promote high-value care.

(e) REPORTS.—

(1) Not later than April 15, 2011, the Institute shall submit to the Secretary and each House of Congress a report containing findings and recommendations of the study conducted under this section.

(2) Following submission of the report under paragraph (1), the Institute shall use the data collected and analyzed in this section to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. Such reports shall include a comparison to the Institute's findings and recommendations regarding the Medicare program. Such reports, and any recommendations, would not be subject to the procedures outlined in section 1160.

(f) HIGH-VALUE CARE DEFINED.—For purposes of this section, the term ''high-value care'' means the efficient delivery of high quality, evidence-based, patient-centered care.

(g) APPROPRIATIONS.—There is appropriated from amounts in the general fund of the Treasury not otherwise appropriated $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDICARE PAYMENTS TO PROMOTE HIGH VALUE HEALTH CARE.

(a) PREPARATION AND SUBMISSION OF IMPLEMENTATION PLANS.—

(1) FINAL IMPLEMENTATION PLAN.—Not later than 240 days after the date of receipt by the Secretary and each House of Congress of the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of the Social Security Act (which may include payment for inpatient and outpatient hospital services for services furnished in PPS and PPS-exempt hospitals, physicians' services, dialysis facility services, skilled nursing facility services, home health services, hospice care, clinical laboratory services, durable medical equipment, and other items and services, but which shall exclude add-on payments for graduate medical education, disproportionate share payments, and health

information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of the Social Security Act) taking into consideration, as appropriate, the recommendations of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participation in the Medicare program under title XVIII of the Social Security Act and preserves access to care for Medicare beneficiaries.

(2) PRELIMINARY IMPLEMENTATION PLAN.—Not later than 90 days after the date the Institute of Medicine submits to each House of Congress the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a preliminary version of the implementation plan provided for under paragraph (1)(A).

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Centers for Medicare & Medicaid Services that over the initial 10-year period in which the plan is implemented, the aggregate level of net expenditures under the Medicare program under title XVIII of the Social Security Act will not exceed the aggregate level of such expenditures that would have occurred if the plan were not implemented.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permitted under title XVIII of the Social Security Act, the Secretary shall specify in the plan the specific waivers required under such title to implement such changes. Except as provided in subsection (c), the Secretary is authorized to waive the requirements so specified in order to implement such changes.

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(b) REVIEW BY MEDPAC AND GAO.—Not later than 45 days after the date the preliminary implementation plan is received by each House of Congress under subsection (a)(2), the Medicare Payment Advisory Committee and the Comptroller General of the United States shall each evaluate such plan and submit to each House of Congress a report containing its analysis and recommendations regarding implementation of the plan, including an analysis of the effects of the proposed changes in the plan on payments and projected spending.

(c) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall include, in applicable proposed rules for the next rulemaking cycle beginning after the Congressional action deadline, appropriate proposals to revise payments under title XVIII of the Social Security Act in accordance with the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required to carry out such plan are effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline. If such a joint resolution is enacted, the Secretary is not authorized to implement such plan and the waiver authority provided under subsection (a)(4) shall no longer be effective.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term ''Congressional action deadline'' means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of such plan by each House of Congress under subsection (a).

(d) CONGRESSIONAL PROCEDURES.—

(1) INTRODUCTION.—On the day on which the final implementation plan is received by the House of Representatives and the Senate under subsection (a), a joint resolution specified in paragraph (5)(A) shall be introduced in the House of Representatives by the majority leader and minority leader of the House of Representatives and in the Senate by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such a plan is received, the joint resolution with respect to such plan shall be introduced in that House, as provided in the preceding sentence, on the first day thereafter on which that House is in session.

(2) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) REPORTING AND DISCHARGE.—Any committee of the House of Representatives to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the House not later than 50 legislative days after the applicable date of introduction of the joint resolution. If a committee fails to report such joint resolution within that period, a motion to discharge the committee from further consideration of the joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the last committee authorized to consider the joint resolution reports it to the House or after the House has disposed of a motion to discharge the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion except 20 minutes of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) PROCEEDING TO CONSIDERATION.—After each committee authorized to consider a joint resolution reports such joint resolution to the House of Representatives or has been discharged from its consideration, a motion to proceed to consider such joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the House of Representatives has disposed of a motion to proceed on the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(C) CONSIDERATION.—The joint resolution shall be considered in the House and shall be considered as read. All points of order against a joint resolution and against its consideration are waived. The previous question shall be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of a joint resolution shall not be in order.

(3) CONSIDERATION IN THE SENATE.—

(A) REPORTING AND DISCHARGE.—Any committee of the Senate to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the Senate within 50 legislative days. If a committee fails to report such joint resolution at the close of the 15th legislative day after its receipt by the Senate, such committee shall be automatically discharged from further consideration of such joint resolution and such joint resolution or joint resolutions shall be placed on the calendar. A vote on final passage of such joint resolution shall be taken in the Senate on or before the close of the second legislative day after such joint resolution is reported by the committee or committees of the Senate to which it was referred, or after such committee or committees have been discharged from further consideration of such joint resolution.

(B) PROCEEDING TO CONSIDERATION.—A motion in the Senate to proceed to the consideration of a joint resolution shall be privileged and not debatable. An amendment to such a motion shall not be in order, nor shall it be in order to move to reconsider the vote by which such a motion is agreed to or disagreed to.

(C) CONSIDERATION.—

(i) Debate in the Senate on a joint resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

(ii) Debate in the Senate on any debatable motion or appeal in connection with a joint resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, except that in the event the manager of the joint resolution is in favor of any such motion or appeal, the time in opposition thereto shall be controlled by the minority leader or a designee. Such leaders, or either of them, may, from time under their control on the passage of a joint resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(iii) A motion in the Senate to further limit debate is not debatable. A motion to recommit a joint resolution is not in order.

(4) RULES RELATING TO SENATE AND HOUSE OF REPRESENTATIVES.—

(A) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by one House of a joint resolution of that House, that House receives from the other House a joint resolution, then the following procedures shall apply:

(i) The joint resolution of the other House shall not be referred to a committee.

(ii) With respect to the joint resolution of the House receiving the resolution, the procedure in that House shall be the same as if no such joint resolution had been received from the other House; but the vote on passage shall be on the joint resolution of the other House.

(B) TREATMENT OF COMPANION MEASURES.—If, following passage of a joint resolution in the Senate, the Senate then receives the companion measure from the House of Representatives, the companion measure shall not be debatable.

(C) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph and the preceding paragraphs are enacted by Congress—

(i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it supersedes other

rules only to the extent that it is inconsistent with such rules; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(5) DEFINITIONS.—In this section:

(A) JOINT RESOLUTION.—The term ''joint resolution'' means only a joint resolution—

(i) which does not have a preamble;

(ii) the title of which is as follows: ''Joint resolution disapproving a Medicare final implementation plan of the Secretary of Health and Human Services submitted under section 1160(a) of the Affordable Health Care for America Act''; and

(iii) the sole matter after the resolving clause of which is as follows: ''That the Congress disapproves the final implementation plan of the Secretary of Health and Human Services transmitted to the Congress on————.'', the blank space being filled with the appropriate date.

(B) LEGISLATIVE DAY.—The term ''legislative day'' means any calendar day excluding any day on which that House was not in session.

(6) BUDGETARY TREATMENT.—For the purposes of consideration of a joint resolution, the Chairmen of the House of Representatives and Senate Committees on the Budget shall exclude from the evaluation of the budgetary effects of the measure, any such effects that are directly attributable to disapproving a Medicare final implementation plan of the Secretary submitted under subsection (a).

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS; QUALITY BONUS PAYMENTS.

(a) PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007, 2008, 2009, and 2010''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2011, 1/12 of the blended benchmark amount determined under subsection (n)(1)''; and

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

''(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3) and (4), the term 'blended benchmark amount' means for an area—

''(A) for 2011 the sum of—

''(i) 2/3 of the applicable amount (as defined in subsection (k)) for the area and year; and

''(ii) 1/3 of the amount specified in paragraph (2) for the area and year;

''(B) for 2012 the sum of—

''(i) 1/3 of the applicable amount for the area and year; and

''(ii) 2/3 of the amount specified in paragraph (2) for the area and year; and

''(C) for a subsequent year the amount specified in paragraph (2) for the area and year.

''(2) SPECIFIED AMOUNT.—The amount specified in this paragraph for an area and year is the amount specified in subsection (c)(1)(D)(i) for the area and year adjusted (in a manner specified by the Secretary) to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4).

''(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in paragraph (2).

''(4) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.''.

(b) QUALITY BONUS PAYMENTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (a), is amended—

(1) in subsection (j), by inserting ''subject to subsection (o),'' after ''For purposes of this part,''; and

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

''(o) QUALITY BASED PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year beginning with 2011, the blended benchmark amount under subsection (n)(1) shall be increased—

''(A) for 2011, by 1.5 percent;

''(B) for 2012, by 3.0 percent; and

''(C) for a subsequent year, by 5.0 percent.

''(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

''(A) QUALIFYING PLAN.—The term 'qualifying plan' means, for a year and subject to paragraph (4), a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system established by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

''(B) QUALIFYING COUNTY.—The term 'qualifying county' means, for a year, a county—

''(i) that ranked within the lowest third of counties in the amount specified in subsection (n)(2) for a year specified by the Secretary; and

''(ii) for which, as of June of a year specified by the Secretary, of the Medicare Advantage eligible individuals residing in the county at least 20 percent of such individuals were enrolled in Medicare Advantage plans.

''(3) DETERMINATIONS OF QUALITY.—

''(A) QUALITY PERFORMANCE.—The Secretary shall provide for the computation of a quality performance score for each Medicare Advantage plan to be applied for each year.

''(B) COMPUTATION OF SCORE.—

''(i) QUALITY PERFORMANCE SORE.—For years before a year specified by the Secretary, the quality performance score for a Medicare Advantage plan shall be computed based on a blend (as designated by the Secretary) of the plan's performance on—

''(I) HEDIS effectiveness of care quality measures;

''(II) CAHPS quality measures; and

''(III) such other measures of clinical quality as the Secretary may specify.

Such measures shall be risk-adjusted as the Secretary deems appropriate.

''(ii) ESTABLISHMENT OF OUTCOME-BASED MEASURES.—By not later than for a year specified by the Secretary, the Secretary shall implement reporting requirements for quality under this section on measures selected under clause (iii) that reflect the outcomes of care experienced by individuals enrolled in Medicare Advantage plans (in addition to measures described in clause (i)). Such measures may include—

''(I) measures of rates of admission and readmission to a hospital;

''(II) measures of prevention quality, such as those established by the Agency for Healthcare Research and Quality (that include hospital admission rates for specified conditions);

''(III) measures of patient mortality and morbidity following surgery;

''(IV) measures of health functioning (such as limitations on activities of daily living) and survival for patients with chronic diseases;

''(V) measures of patient safety; and

''(VI) other measure of outcomes and patient quality of life as determined by the Secretary.

Such measures shall be risk-adjusted as the Secretary deems appropriate. In determining the quality measures to be used under this clause, the Secretary shall take into consideration the recommendations of the Medicare Payment Advisory Commission in its report to Congress under section 168 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) and shall provide preference to measures collected on and comparable to measures used in measuring quality under parts A and B.

''(iii) RULES FOR SELECTION OF MEASURES.—The Secretary shall select measures for purposes of clause (ii) consistent with the following:

''(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) Prior to any measure being selected under this clause, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

''(iv) TRANSITIONAL USE OF BLEND.—For payments for years specified by the Secretary, the Secretary may compute the quality performance score for a Medicare Advantage plan based on a blend of the measures specified in clause (i) and the measures described in clause (ii) and selected under clause (iii).

''(v) USE OF QUALITY OUTCOMES MEASURES.—For payments beginning with a year specified by the Secretary (beginning after the years specified for section (iv)), the preponderance of measures used under this paragraph shall be quality outcomes measures described in clause (ii) and selected under clause (iii).

''(C) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of quality performance data described in this paragraph (in order to determine a quality performance score under this paragraph) in such time and manner as the Secretary shall specify.

''(4) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall provide for publication on the website for the Medicare program of the information described in the previous sentence.

''(5) AUTHORITY TO DISQUALIFY DEFICIENT PLANS.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan's compliance with rules for Medicare Advantage plans under this part.''.

SEC. 1162. AUTHORITY FOR SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.

Section 1853(a)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)(ii)) is amended—

(1) in the matter before subclause (I), by striking ''through 2010'' and inserting ''and each subsequent year''; and

(2) in subclause (II)—

(A) by inserting ''periodically'' before ''conduct an analysis'';

(B) by inserting ''on a timely basis'' after ''are incorporated''; and

(C) by striking ''only for 2008, 2009, and 2010'' and inserting ''for 2008 and subsequent years''.

SEC. 1163. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) 2-WEEK PROCESSING PERIOD FOR ANNUAL ENROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(v) with respect to 2011 and succeeding years, the period beginning on November 1 and ending on December 15 of the year before such year.''.

(b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN ENROLLMENT PERIOD (OEP).—Effective for plan years beginning with 2011, paragraph (2) of such section is amended by striking subparagraph (C).

SEC. 1164. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), by striking ''January 1, 2010'' and inserting ''January 1, 2012''; and

(2) in clause (iii), by striking ''the service area for the year'' and inserting ''the portion of the plan's service area for the year that is within the service area of a reasonable cost reimbursement contract''.

SEC. 1165. LIMITATION OF WAIVER AUTHORITY FOR EMPLOYER GROUP PLANS.

(a) IN GENERAL.—The first sentence of each of paragraphs (1) and (2) of section 1857(i) of the Social Security Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: '', but only if 90 percent of the Medicare Advantage eligible individuals enrolled under such plan reside in a county in which the MA organization offers an MA local plan''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for plan years beginning on or after January 1, 2011, and shall not apply to plans which were in effect as of December 31, 2010.

SEC. 1166. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.

(a) REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries; and the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data.

(b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not later than January 1, 2012, the Secretary shall implement necessary improvements to the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)), taking into account the evaluation under subsection (a).

SEC. 1167. ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.

(a) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(b) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 1168. STUDY REGARDING THE EFFECTS OF CALCULATING MEDICARE ADVANTAGE PAYMENT RATES ON A REGIONAL AVERAGE OF MEDICARE FEE FOR SERVICE RATES.

(a) IN GENERAL.—The Administrator of the Centers for Medicare and Medicaid Services shall conduct a study to determine the potential effects of calculating Medicare Advantage payment rates on a more aggregated geographic basis (such as metropolitan statistical areas or other regional delineations) rather than using county boundaries. In conducting such study, the Administrator shall consider the effect of such alternative geographic basis on the following:

(1) The quality of care received by Medicare Advantage enrollees.

(2) The networks of Medicare Advantage plans, including any implications for providers contracting with Medicare Advantage plans.

(3) The predictability of benchmark amounts for Medicare advantage plans.

(b) CONSULTATIONS.—In conducting the study, the Administrator shall consult with the following:

(1) Experts in health care financing.

(2) Representatives of foundations and other nonprofit entities that have conducted or supported research on Medicare financing issues.

(3) Representatives from Medicare Advantage plans.

(4) Such other entities or people as determined by the Secretary.

(c) REPORT.—Not later than one year after the date of the enactment of this Act, the Administrator shall transmit a report to the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Administrator considers appropriate.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking ''or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

''(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.''.

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(7) of such Act is amended to read as follows:

''(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Advantage plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2011.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2011.

SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLLEES IN PLANS WITH ENROLLMENT SUSPENSION.

Section 1851(e)(4) of the Social Security Act (42 U.S.C. 1395w(e)(4)) is amended—

(1) in subparagraph (C), by striking at the end ''or'';

(2) in subparagraph (D)—

(A) by inserting '', taking into account the health or well-being of the individual'' before the period; and

(B) by redesignating such subparagraph as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or''.

SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21), as previously amended by this subtitle, is amended by adding at the end the following new subsection:

''(p) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

''(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year (beginning with 2011), for each MA plan contract, the medical loss ratio of the plan in the previous year.

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—Each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the medical loss ratio on a timely basis.

''(B) DATA FOR 2010 AND 2011.—The data submitted under subparagraph (A) for 2010 and for 2011 shall be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

''(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year, beginning with 2012, shall be submitted based on the standardized elements and definitions developed under paragraph (3).

''(3) DEVELOPMENT OF DATA REPORTING STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2012, of data necessary for the calculation of the medical loss ratio for MA plans. Not later than December 31, 2010, the Secretary shall publish a report describing the elements and definitions so developed.

''(B) CONSULTATION.—The Secretary shall consult with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

''(4) MEDICAL LOSS RATIO TO BE DEFINED.—For purposes of this part, the term 'medical loss ratio' has the meaning given such term by the Secretary, taking into account the meaning given such term by the Health

Choices Commissioner under section 116 of the Affordable Health Care for America Act.''.

(b) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least .85—

''(A) the Secretary shall require the Medicare Advantage organization offering the plan to give enrollees a rebate (in the second succeeding contract year) of premiums under this part (or part B or part D, if applicable) by such amount as would provide for a benefits ratio of at least .85;

''(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

''(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.''.

SEC. 1174. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after ''section 1858(c))'' the following: '', and data submitted with respect to risk adjustment under section 1853(a)(3)''.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act, as amended by section 1173, is amended by adding at the end the following new paragraph:

''(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

''(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall include terms that inform the organization of the provisions in subsection (d).

''(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.''.

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2011.

SEC. 1175. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

''(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid by an MA organization under this subsection.''.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids under this section in the same manner as it applies to bids by an MA organization under such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids for contract years beginning on or after January 1, 2011.

SEC. 1175A. STATE AUTHORITY TO ENFORCE STANDARDIZED MARKETING REQUIREMENTS.

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

(1) by striking ''The standards'' and inserting ''(A) IN GENERAL.—The standards'' with appropriate indentation that is the same as for the subparagraph (B) added by paragraph (2); and

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

''(B) ENFORCEMENT OF FEDERAL STANDARDS PERMITTED.—

''(i) IN GENERAL.—Subject to the subsequent provision of this subparagraph, nothing in this title shall be construed to prohibit a State from conducting a market conduct examination or from imposing civil monetary penalties, in accordance with laws and procedures of the State, against Medicare Advantage organizations, PDP sponsors, or agents or brokers of such organizations or sponsors for violations of the marketing requirements under subsections (h)(4), (h)(6), and (j) of section 1851 and section 1857(g)(1)(E).

''(ii) ADDITIONAL REMEDIES RESULTING FROM FEDERAL-STATE COOPERATION.—

''(I) STATE RECOMMENDATION.—A State may recommend to the Secretary the imposition of an intermediate sanction not described in clause (i) (such as those available under section 1857(g)) against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in such clause.

''(II) RESPONSE TO RECOMMENDATION.—Not later than 30 days after receipt of a recommendation under subclause (I) from a State, with respect to a violation described in clause (i), the Secretary shall respond in writing to the State indicating the progress of any investigation involving such violation, whether the Secretary intends to pursue the recommendation from the State, and in the case the Secretary does not intend to pursue such recommendation, the reason for such decision.

''(iii) NON-DUPLICATION OF PENALTIES.—In the case that an action has been initiated against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation of a marketing requirement under subsection (h)(4), (h)(6), or (j) of section 1851 or section 1857(g)(1)(E)—

''(I) in the case such action has been initiated by the Secretary, no State may bring an action under such applicable subsection or section against such organization, sponsor, agent, or broker with respect to such violation during the pendency period of the action initiated by the Secretary and, if a penalty is imposed pursuant to such action, after such period; and

''(II) in the case such action has been initiated by a State, the Secretary may not bring an action under such applicable subsection or section against such organization, sponsor, agent, or broker with respect to such violation during the pendency period of the action initiated by the Secretary and, if a penalty is imposed pursuant to such action, after such period.

Nothing in this clause shall be construed as limiting the ability of the Secretary to impose any sanction other than a civil monetary penalty under section 1857 against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in clause (i).

''(iv) CONSTRUCTION.—Nothing in this subparagraph shall be construed as affecting any State authority to regulate brokers described in this paragraph or any other conduct of a Medicare Advantage organization or PDP sponsor.''.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS

SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN ENROLLMENT PERIOD OF INDIVIDUALS INTO CHRONIC CARE SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new subparagraph:

''(C) The plan does not enroll an individual on or after January 1, 2011, other than—

''(i) during an annual, coordinated open enrollment period; or

''(ii) during a special election period consisting of the period for which the individual has a chronic condition that qualifies the individual as an individual described in subsection (b)(6)(B)(iii) for such plan and ending on the date on which the individual enrolls in such a plan on the basis of such condition.

If an individual is enrolled in such a plan on the basis of a chronic condition and becomes eligible for another such plan on the basis of another chronic condition, the other plan may enroll the individual on the basis of such other chronic condition during a special enrollment period described in clause (ii). An individual is eligible to apply such clause only once on the basis of any specific chronic condition.''.

SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS PLANS TO RESTRICT ENROLLMENT; SERVICE AREA MORATORIUM FOR CERTAIN SNPS.

(a) IN GENERAL.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''January 1, 2011'' and inserting ''January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the Affordable Health Care for America Act)''.

(b) EXTENSION OF CERTAIN PLANS.—

(1) PLANS DESCRIBED.—For purposes of Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), a plan described in this paragraph is a Medicare Advantage dual eligible special needs plan that—

(A) whose sponsoring Medicare Advantage organization, as of the date enactment of the Affordable Health Care for America Act, has a contract with a State Medicaid Agency that participated in the ''Demonstrations Serving Those Dually-Eligible for Medicare and Medicaid'' under the Medicare program; and

(B) that has been approved by the Centers for Medicare & Medicaid Services as a dual eligible special needs plan and that offers integrated Medicare and Medicaid services under a contract with the State Medicaid agency.

(2) ANALYSIS; REPORT.—

(A) ANALYSIS.—The Secretary of Health and Human Services shall provide, through a contract with an independent health services evaluation organization, for an analysis of the plans described in paragraph (1) with regard to the impact of such plans on cost, quality of care, patient satisfaction, and other subjects specified by the Secretary. Such report also will identify statutory changes needed to simplify access to needed services, improve coordination of benefits and services and ensure protection for dual eligibles as appropriate.

(B) REPORT.—Not later than December 31, 2011, the Secretary shall submit to the Congress a report on the analysis under subparagraph (A) and shall include in such report such recommendations with regard to the treatment of such plans as the Secretary deems appropriate.

(c) EXTENSION OF SERVICE AREA MORATORIUM FOR CERTAIN SNPS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

SEC. 1178. EXTENSION OF MEDICARE SENIOR HOUSING PLANS.

Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of a Medicare Advantage senior housing facility plan described in paragraph (2) and for periods before January 1, 2013—

''(A) the service area of such plan may be limited to a senior housing facility in a geographic area;

''(B) the service area of such plan may not be expanded; and

''(C) additional senior housing facilities may not be serviced by such plan.

''(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

''(A)(i) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

''(ii) provides primary care services onsite and has a ratio of accessible providers to beneficiaries that the Secretary determines is adequate, taking into consideration the number of residents onsite, the health needs of those residents, and the accessibility of providers offsite; and

''(iii) provides transportation services for beneficiaries to providers outside of the facility; and

''(B) is offered by a Medicare Advantage organization that has offered at least 1 plan described in subparagraph (A) for at least 1 year prior to January 1, 2010, under a demonstration project established by the Secretary.''.

Subtitle E—Improvements to Medicare Part D

SEC. 1181. ELIMINATION OF COVERAGE GAP.

(a) IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.—Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)''; and

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

''(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

''(A) IN GENERAL.—For plan years beginning during 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

''(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

''(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

''(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.''.

(b) ADDITIONAL CLOSURE IN GAP BEGINNING IN 2011.—Section 1860D–2(b) of such Act (42 U.S.C. 1395w–102(b)) as amended by subsection (a), is further amended—

(1) in paragraph (3)(A), by striking ''and (7)'' and inserting '', (7), and (8)'' ;

(2) in paragraph (4)(B)(i), by inserting ''subject to paragraph (8)'' after ''purposes of this part''; and

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

''(8) PHASED-IN ELIMINATION OF COVERAGE GAP.—

''(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket threshold from the amounts otherwise computed until, beginning in 2019, there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

''(B) INCREASE IN INITIAL COVERAGE LIMIT.—

''(i) IN GENERAL.—For a year beginning with 2011, subject to clause (ii), the initial coverage limit otherwise computed without regard to this paragraph shall be increased by the cumulative ICL phase-in percentage (as defined in clause (iii) for the year) times the out-of-pocket gap amount (as defined in subparagraph (D)) for the year.

''(ii) MAINTENANCE OF 2010 INITIAL COVERAGE LIMIT LEVEL.—If for a year the initial coverage limit otherwise computed under this paragraph would be less than the initial coverage limit applied during 2010, taking into account paragraph (7), the initial coverage limit for that year shall be such initial coverage limit as so applied during 2010.

''(iii) CUMULATIVE PHASE-IN PERCENTAGE.—

''(I) IN GENERAL.—For purposes of this paragraph, subject to subclause (II), the term 'cumulative ICL phase-in percentage' means for a year the sum of the annual ICL phase-in percentage (as defined in clause (iv)) for the year and the annual ICL phase-in percentages for each previous year beginning with 2011.

''(II) LIMITATION.—If the sum of the cumulative ICL phase-in percentage and the cumulative OPT phase-in percentage (as defined in subparagraph (C)(iii)) for a year would otherwise exceed 100 percent, each such percentage shall be reduced in a proportional amount so the sum does not exceed 100 percent.

''(iv) ANNUAL ICL PHASE-IN PERCENTAGE.—For purposes of this paragraph, the term 'annual ICL phase-in percentage' means—

''(I) for 2011, 8.25 percent;

''(II) for 2012, 2013, and 2014, 4.5 percent;

''(III) for 2015 and 2016, 6 percent;

''(IV) for 2017, 7.5 percent;

''(V) for 2018, 8 percent; and

''(VI) for 2019, 8 percent, or such other percent as may be necessary to provide for a full continuation of coverage as described in subparagraph (A) in that year.

''(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—

''(i) IN GENERAL.—For a year beginning with 2011, subject to clause (ii), the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by the cumulative OPT phase-in percentage (as defined in clause (iii) for the year) of the out-of-pocket gap amount for the year multiplied by 1.75.

''(ii) MAINTENANCE.—The Secretary shall adjust the annual out-of-pocket threshold for a year to the extent necessary to ensure that the sum of the initial coverage limit described in subparagraph (A) and the out-of-pocket gap amount (defined in subparagraph (D)), as determined for the year pursuant to the provisions of this paragraph for such year, does not exceed such sum that would have applied if this paragraph did not apply.

''(iii) CUMULATIVE OPT PHASE-IN PERCENTAGE.—For purposes of this paragraph, subject to subparagraph (B)(iii)(II), the term 'cumulative OPT phase-in percentage' means for a year the sum of the annual OPT phase-in percentage (as defined in clause (iv)) for the year and the annual OPT phase-in percentages for each previous year beginning with 2011.

''(iv) ANNUAL OPT PHASE-IN PERCENTAGE.—For purposes of this paragraph, the term 'annual OPT phase-in percentage' means—

''(I) for 2011, 0 percent;

''(II) for 2012, 2013, and 2014, 4.5 percent;

''(III) for 2015 and 2016, 6 percent;

''(IV) for 2017, 7.5 percent; and

''(V) for 2018 and 2019, 8 percent.

''(D) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

''(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

''(ii) the sum of—

''(I) the annual deductible under paragraph (1) for the year; and

''(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.

''(E) RELATION TO AAHCA TRANSITIONAL INCREASE.—Except as otherwise specifically provided, this paragraph shall be applied as if no increase had been made in the initial coverage limit under paragraph (7).''.

(c) REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR REBATE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(A) in subsection (e)(1), in the matter before subparagraph (A), by inserting ''and subsection (f)'' after ''this subsection''; and

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

''(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR REBATE ELIGIBLE INDIVIDUALS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2011, in this part, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

''(B) 2010 PLAN YEAR REQUIREMENT.—Any drug or biological product manufactured by a manufacturer that declines to enter into a rebate agreement described in paragraph (2) for the period beginning on January 1, 2010, and ending on December 31, 2010, shall not be included as a 'covered part D drug ' for the subsequent plan year.

''(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the

manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2009, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2009, to any rebate eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA organization under part C for such period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3), or 30 days after the receipt of information under subparagraph (D) of paragraph (3), as determined by the Secretary. Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement relating to compliance, penalties, and program evaluations, investigations, and audits that are similar to the terms and conditions for rebate agreements under paragraphs (3) and (4) of section 1927(b).

''(3) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer and dispensed to a rebate eligible individual, shall be equal to the product of—

''(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively; and

''(ii) the amount (if any) by which—

''(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

''(II) the average Medicare drug program rebate eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

''(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period—

''(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(c) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

''(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

''(C) AVERAGE MEDICARE DRUG PROGRAM REBATE ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program rebate eligible rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

''(i) the product, for each such sponsor or organization, of—

''(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to rebate eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not rebate eligible individuals; and

''(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA organization; divided by

''(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA organizations.

''(D) USE OF ESTIMATES.—The Secretary may establish a methodology for estimating the average Medicare drug program rebate eligible rebate amounts for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates under this section. If the Secretary elects to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall establish a reconciliation process for adjusting manufacturer rebate payments not later than 3 months after the date that manufacturers receive the information collected under section 1860D–12(b)(7)(B).

''(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

''(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

''(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

''(A) REBATE ELIGIBLE INDIVIDUAL.—The term 'rebate eligible individual'—

''(i) means a full-benefit dual eligible individual (as defined in section 1935(c)(6)); and

''(ii) includes, for drugs dispensed after December 31, 2014, a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A)).

''(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).

''(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning on January 1, 2010, and ending on December 31, 2010.''.

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURES RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

''(B) REPORT FORM AND CONTENTS.—Not later than a date specified by the Secretary, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

''(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to rebate eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

''(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

''(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to rebate eligible Medicare drug plan enrollees and PDP enrollees who are not rebate eligible Medicare drug plan enrollees; and

''(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program rebate eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

''(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

''(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

''(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

''(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

''(iii) clause (iv) of such subparagraph shall not apply.

''(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

''(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

''(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

''(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

''(D) REPORTING REQUIREMENT RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).''.

(3) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of such Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

''(6) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).''.

SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN ORIGINAL COVERAGE GAP.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102), as amended by section 1181, is amended—

(1) in subsection (b)(4)(C)(ii), by inserting ''subject to subsection (g)(2)(C),'' after ''(ii)'';

(2) in subsection (e)(1), in the matter before subparagraph (A), by striking ''subsection (f)'' and inserting ''subsections (f) and (g)'' after ''this subsection''; and

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

''(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

''(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect for all qualifying drugs (as defined in paragraph (5)(A)) a discount agreement described in paragraph (2).

''(2) DISCOUNT AGREEMENT.—

''(A) PERIODIC DISCOUNTS.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(A)) of the manufacturer dispensed to a qualifying enrollee after January 1, 2010, insofar as the individual is in the original gap in coverage (as defined in paragraph (5)(E)).

''(B) DISCOUNT AGREEMENT.—Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement, including terms and conditions relating to compliance, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1927(b), except that—

''(i) discounts shall be applied under this subsection to prescription drug plans and MA–PD plans instead of State plans under title XIX;

''(ii) PDP sponsors and MA organizations shall be responsible, instead of States, for provision of necessary utilization information to drug manufacturers; and

''(iii) sponsors and MA organizations shall be responsible for reporting information on drug-component negotiated price.

''(C) COUNTING DISCOUNT TOWARD TRUE OUT-OF-POCKET COSTS.—Under the discount agreement, in applying subsection (b)(4), with regard to subparagraph (C)(i) of such subsection, if a qualified enrollee purchases the qualified drug insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the amount of the discount under the agreement shall be treated and counted as costs incurred by the plan enrollee.

''(3) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price (as defined in paragraph (5)(C)) for qualifying drugs for the period involved.

''(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

''(A) insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the sponsor or plan shall provide the discount to the enrollee at the time the enrollee pays for the drug; and

''(B) insofar as the enrollee is in the portion of the original gap in coverage (as defined in paragraph (5)(E)) that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

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

''(A) QUALIFYING DRUG.—The term 'qualifying drug' means, with respect to a prescription drug plan or MA–PD plan, a drug or biological product that—

''(i)(I) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application;

''(II) is a drug that was originally marketed under an original new drug application approved by the Food and Drug Administration; or

''(III) is a biological product as approved under Section 351(a) of the Public Health Services Act;

''(ii) is covered under the formulary of the plan or is treated as covered under the formulary of the plan as a result of a coverage determination or appeal under subsection (g) or (h) of section 1860D–4; and

''(iii) is dispensed to an individual who is in the original gap in coverage.

''(B) QUALIFYING ENROLLEE.—The term 'qualifying enrollee' means an individual enrolled in a prescription drug plan or MA–PD plan other than such an individual who is a subsidy-eligible individual (as defined in section 1860D–14(a)(3)).

''(C) DRUG-COMPONENT NEGOTIATED PRICE.—The term 'drug-component negotiated price' means, with respect to a qualifying drug, the negotiated price (as defined in section 423.100 of title 42, Code of Federal Regulations, as in effect on the date of enactment of this subsection), as determined without regard to any dispensing fee, of the drug under the prescription drug plan or MA–PD plan involved.

''(D) ACTUAL GAP IN COVERAGE.—The term 'actual gap in coverage' means the gap in prescription drug coverage that occurs between the initial coverage limit (as modified under paragraph (7) and subparagraph (B) of paragraph (8) of subsection (b)) and the annual out-of-pocket threshold (as modified under subparagraph (C) of such subsection).

''(E) ORIGINAL GAP IN COVERAGE.—The term 'original in gap coverage' means the gap in prescription drug coverage that would occur between the initial coverage limit (described in subsection (b)(3)) and the out-of-pocket threshold (as defined in subsection (b)(4)(B)) if subsections (b)(7) and (b)(8) did not apply.

''(6) SPECIAL RULE FOR 2010.—For the period beginning January 1, 2010, and ending December 31, 2010, the Secretary may—

''(A) enter into agreements with manufacturers to directly receive the discount amount described in paragraph (3);

''(B) collect the necessary information from prescription drug plans and MA-PD plans to calculate the discount amount described in such paragraph; and

''(C) provide the discount described in such paragraph to beneficiaries as close as practicable after the point of sale.

''(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning on January 1, 2010, and ending on December 31, 2010.''.

SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.

(a) PART D SUBMISSION.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)), as amended by section 172(a)(1) of Public Law 110–275, is amended by striking paragraph (5) and redesignating paragraph (6) and paragraph (7), as added by section 1181(c)(2)(A), as paragraph (5) and paragraph (6), respectively.

(b) SUBMISSION TO MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)), as added by section 171(b) of Public Law 110–275 and amended by section 172(a)(2) of such Public Law and section 1181 of this Act, is amended by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C) respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning with 2010.

SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''and subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 1185. NO MID-YEAR FORMULARY CHANGES PERMITTED.

(a) IN GENERAL.—Section 1860D–4(b)(3)(E) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)(E)) is amended—

(1) in the heading, by inserting ''; CERTAIN FORMULARY CHANGES ONLY BEFORE INITIATING MARKETING FOR A PLAN YEAR'' after ''STATUS OF DRUG'';

(2) by striking ''Any removal'' and inserting ''(i) NOTICE.—Any removal'' with the same indentation as the clause added by paragraph (2);

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

''(ii) CERTAIN CHANGES IN FORMULARY ONLY BEFORE INITIATING MARKETING FOR A PLAN YEAR.—Any removal of a covered part D drug from a formulary used by a PDP sponsor of a prescription drug plan (or MA organization of a MA–PD plan) or any other material change to the formulary so as to reduce the coverage (or increase the cost-sharing) of the drug under the plan for a plan year shall take effect by a date specified by the Secretary but no later than the start of plan marketing activities for the plan year. In addition to any exceptions to the previous sentence specified by the Secretary, the previous sentence shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management applied to—

''(I) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 201.57(c)(1) of title 21, Code of Federal Regulations (or a successor regulation); or

''(II) a drug required under subsection (c)(2) of section 505–1 of the Federal Food, Drug, and Cosmetic Act to have a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contract years beginning on or after January 1, 2011.

SEC. 1186. NEGOTIATION OF LOWER COVERED PART D DRUG PRICES ON BEHALF OF MEDICARE BENEFICIARIES.

(a) NEGOTIATION BY SECRETARY.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and inserting the following:

''(i) NEGOTIATION OF LOWER DRUG PRICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan.

''(2) NO CHANGE IN RULES FOR FORMULARIES.—

''(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to authorize the Secretary to establish or require a particular formulary.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as affecting the Secretary's authority to ensure appropriate and adequate access to covered part D drugs under prescription drug plans and under MA-PD plans, including compliance of such plans with formulary requirements under section 1860D–4(b)(3).

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the sponsor of a prescription drug plan, or an organization offering an MA-PD plan, from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated under paragraph (1).

''(4) ANNUAL REPORTS TO CONGRESS.—Not later than June 1, 2011, and annually thereafter, the Secretary shall submit to the Committees on Ways and Means, Energy and Commerce, and Oversight and Government Reform of the House of Representatives and the Committee on Finance of the Senate a report on negotiations conducted by the Secretary to achieve lower prices for Medicare beneficiaries, and the prices and price discounts achieved by the Secretary as a result of such negotiations.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall first apply to negotiations and prices for plan years beginning on January 1, 2011.

SEC. 1187. ACCURATE DISPENSING IN LONG-TERM CARE FACILITIES.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(3) REDUCTION OF WASTEFUL DISPENSING.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2012, a PDP sponsor offering a prescription drug plan and MA organization offering a MA–PD plan under part C shall have in place the utilization management techniques established under subparagraph (B).

''(B) REQUIREMENTS.—The Secretary shall establish utilization management techniques, such as daily, weekly, or automated dose dispensing, to apply to PDP sponsors and MA organizations to reduce the quantities of covered part D drugs dispensed to enrollees who are residing in long-term care facilities in order to reduce waste associated with unused medications.

''(C) CONSULTATION.—In establishing the requirements under subparagraph (A), the Secretary shall consult with the Administrator of the Environmental Protection Agency, Administrator of the Food and Drug Administration, Administrator of the Drug Enforcement Administration, State Boards of Pharmacy, pharmacy and physician organizations, and other appropriate stakeholders to study and determine additional methods for prescription drug plans to reduce waste associated with unused prescription drugs.''.

SEC. 1188. FREE GENERIC FILL.

(a) IN GENERAL.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (C), by striking ''of 1996'' and all that follows and inserting ''of 1996;'';

(2) in the first subparagraph (D), by striking ''promulgated'' and all that follows and inserting ''promulgated;'';

(3) by redesignating the second subparagraph (D) as a subparagraph (E) and by striking the period at the end of such subparagraph and inserting ''; and''; and

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

''(F) with regard to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, a reduction in or waiver of the copayment amount under the plan given to an individual to induce the individual to switch to a generic, bioequivalent drug, or biosimilar.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act and shall first apply with respect to remuneration offered, paid, solicited, or received on or after January 1, 2011.

SEC. 1189. STATE CERTIFICATION PRIOR TO WAIVER OF LICENSURE REQUIREMENTS UNDER MEDICARE PRESCRIPTION DRUG PROGRAM.

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

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

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

''(5) STATE CERTIFICATION REQUIRED.—

''(A) IN GENERAL.—Except as provided in section 1860D–21(f)(4), the Secretary may only grant a waiver under paragraph (1)(A) if the Secretary has received a certification from the State insurance commissioner that the prescription drug plan has a substantially complete application pending in the State.

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

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

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

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

(b) EXCEPTION FOR PACE PROGRAMS.—Section 1860D–21(f) of such Act (42 U.S.C. 1395w–131(f)) is amended—

(1) in paragraph (1), by striking ''paragraphs (2) and (3)'' and inserting ''the succeeding paragraphs''; and

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

''(4) INAPPLICABILITY OF CERTAIN LICENSURE WAIVER REQUIREMENTS.—The provisions of paragraph (1) of section 1860D–12(c) (relating to waiver of licensure under certain circumstances) shall apply without regard to paragraph (5) of such section in the case of a PACE program that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2010.

Subtitle F—Medicare Rural Access Protections

SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.

(a) ADDITIONAL TELEHEALTH SITE.—

(1) IN GENERAL.—Paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new subclause:

''(IX) A renal dialysis facility.''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) in the heading, by adding at the end the following: ''TELEHEALTH ADVISORY COMMITTEE''; and

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

''(c) TELEHEALTH ADVISORY COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall appoint a Telehealth Advisory Committee (in this subsection referred to as the 'Advisory Committee') to make recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

''(2) MEMBERSHIP; TERMS.—

''(A) MEMBERSHIP.—

''(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

''(I) 5 shall be practicing physicians;

''(II) 2 shall be practicing non-physician health care practitioners; and

''(III) 2 shall be administrators of telehealth programs.

''(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

''(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

''(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

''(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

''(IV) take into account the recommendations of stakeholders.

''(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

''(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

''(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

''(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.''

(2) FOLLOWING RECOMMENDATIONS.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

''(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.''

(3) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

(c) HOSPITAL CREDENTIALING OF TELEMEDICINE PHYSICIANS AND PRACTITIONERS.—

(1) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance for hospitals (as defined in paragraph (4)) to simplify requirements regarding compiling practitioner credentials for the purpose of rendering a medical staff privileging decision (under bylaws of the type described in section 1861(e)(3) of the Social Security Act) for physicians and practitioners (as defined in paragraph (4)) delivering telehealth services that are furnished via a telecommunications system.

(2) FLEXIBILITY IN ACCEPTING CREDENTIALING BY ANOTHER MEDICARE PARTICIPATING HOSPITAL.—

(A) IN GENERAL.—Such guidance shall permit a hospital to accept credentialing packages compiled by another hospital participating under Medicare with regard to physicians and practitioners who seek medical staff privileges in the hospital to provide telehealth services via a telecommunications system from a site other than the hospital where the patient is located.

(B) CONSTRUCTION.—Nothing in this subsection shall be construed to require a hospital to accept the credentialing package compiled by another facility.

(C) NO OVERSIGHT REQUIRED.—If a hospital does accept the credentialing materials prepared by another hospital, the hospital shall not be required to exercise oversight over the other hospital's process for compiling and verifying credentials.

(D) PRIVILEGING.—This paragraph shall only apply to credentialing and does not relieve a hospital from any applicable privileging requirements.

(3) CONSTRUCTION.—This subsection shall not be construed as limiting the ability of the Secretary to issue additional guidance regarding the requirements for the compilation of credentials for physicians and practitioners not described in paragraph (1).

(4) DEFINITIONS.—In this subsection:

(A) The term ''hospital'' has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x) and includes a critical access hospital (as defined in subsection (mm)(1) of such section).

(B) The term ''physician'' has the meaning given such term in subsection (r) of such section.

(C) The term ''practitioner'' means a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking '''2010'' and inserting ''2012''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, 2010, or 2011''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2012''.

SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.

(a) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''September 30, 2009'' and inserting ''September 30, 2011''.

(b) USE OF PARTICULAR WAGE INDEX FOR FISCAL YEAR 2010.—For purposes of implementation of the amendment made by subsection (a) for fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 1008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, 2010, and 2011''.

SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

(a) IN GENERAL.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''; and

(B) in each of clauses (i) and (ii), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

(b) AIR AMBULANCE IMPROVEMENTS.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''ending on December 31, 2009'' and inserting ''ending on December 31, 2011''.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

(a) APPLICATION OF HIGHEST LEVEL PERMITTED UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–14(a)(1) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)) is amended in the matter before subparagraph (A), by inserting ''(or, beginning with 2012, paragraph (3)(E))'' after ''paragraph (3)(D)''.

(2) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of such Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2012)'' after ''subsequent year'';

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

''(III) for 2012, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.''; and

(E) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

(A) by striking ''effective beginning with January 1, 2010'' and inserting ''effective for the period beginning with January 1, 2010, and ending with December 31, 2011''; and

(B) by inserting before the period at the end the following: ''or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations for income-related subsidies and medicare cost-sharing furnished for periods beginning on or after January 1, 2012.

SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(1) by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

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

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1932, or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—

(1) IN GENERAL.—Clause (iii) of section 1860D–14(a)(3)(E) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is amended to read as follows:

''(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

''(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

''(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning January 1, 2010.

(b) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—For provision authorizing disclosure of return information to facilitate identification of individuals likely to be ineligible for low-income subsidies under Medicare prescription drug program, see section 1801.

SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIMBURSEMENTS FOR RETROACTIVE LOW INCOME SUBSIDY ENROLLMENT.

(a) IN GENERAL.—In the case of a retroactive LIS enrollment beneficiary who is enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the beneficiary (or any eligible third party) is entitled to reimbursement by the plan for covered drug costs incurred by the beneficiary during the retroactive coverage period of the beneficiary in accordance with subsection (b) and in the case of such a beneficiary described in subsection (c)(4)(A)(i), such reimbursement shall be made automatically by the plan upon receipt of appropriate notice the beneficiary is eligible for assistance described in such subsection (c)(4)(A)(i) without further information required to be filed with the plan by the beneficiary.

(b) ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—

(1) LINE-ITEM DESCRIPTION.—Each reimbursement made by a prescription drug plan or MA–PD plan under subsection (a) shall include a line-item description of the items for which the reimbursement is made.

(2) TIMING OF REIMBURSEMENTS.—A prescription drug plan or MA–PD plan must make a reimbursement under subsection (a) to a retroactive LIS enrollment beneficiary, with respect to a claim, not later than 45 days after—

(A) in the case of a beneficiary described in subsection (c)(4)(A)(i), the date on which the plan receives notice from the Secretary that the beneficiary is eligible for assistance described in such subsection; or

(B) in the case of a beneficiary described in subsection (c)(4)(A)(ii), the date on which the beneficiary files the claim with the plan.

(3) REPORTING REQUIREMENT.—For each month beginning with January 2011, each prescription drug plan and each MA–PD plan shall report to the Secretary the following:

(A) The number of claims the plan has readjudicated during the month due to a beneficiary becoming retroactively eligible for subsidies available under section 1860D–14 of the Social Security Act.

(B) The total value of the readjudicated claim amount for the month.

(C) The Medicare Health Insurance Claims Number of beneficiaries for whom claims were readjudicated.

(D) For the claims described in subparagraphs (A) and (B), an attestation to the Administrator of the Centers for Medicare & Medicaid Services of the total amount of reimbursement the plan has provided to beneficiaries for premiums and cost-sharing that the beneficiary overpaid for which the plan received payment from the Centers for Medicare & Medicaid Services.

(c) DEFINITIONS.—For purposes of this section:

(1) COVERED DRUG COSTS.—The term ''covered drug costs'' means, with respect to a retroactive LIS enrollment beneficiary enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the amount by which—

(A) the costs incurred by such beneficiary during the retroactive coverage period of the beneficiary for covered part D drugs, premiums, and cost-sharing under such title; exceeds

(B) such costs that would have been incurred by such beneficiary during such period if the beneficiary had been both enrolled in the plan and recognized by such plan as qualified during such period for the low income subsidy under section 1860D–14 of the Social Security Act to which the individual is entitled.

(2) ELIGIBLE THIRD PARTY.—The term ''eligible third party'' means, with respect to a retroactive LIS enrollment beneficiary, an organization or other third party that is owed payment on behalf of such beneficiary for covered drug costs incurred by such beneficiary during the retroactive coverage period of such beneficiary.

(3) RETROACTIVE COVERAGE PERIOD.—The term ''retroactive coverage period'' means—

(A) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(i), the period—

(i) beginning on the effective date of the assistance described in such paragraph for which the individual is eligible; and

(ii) ending on the date the plan effectuates the status of such individual as so eligible; and

(B) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(ii), the period—

(i) beginning on the date the individual is both entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act and eligible for medical assistance under a State plan under title XIX of such Act; and

(ii) ending on the date the plan effectuates the status of such individual as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act).

(4) RETROACTIVE LIS ENROLLMENT BENEFICIARY.—

(A) IN GENERAL.—The term ''retroactive LIS enrollment beneficiary'' means an individual who—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title) and subsequently becomes eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act), an individual receiving a low-income subsidy under section 1860D–14 of such Act, an individual receiving assistance under the Medicare Savings Program implemented under clauses (i), (iii), and (iv) of section 1902(a)(10)(E) of such Act, or an individual receiving assistance under the supplemental security income program under section 1611 of such Act; or

(ii) subject to subparagraph (B)(i), is a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled in such a plan under section 1860D–1(b)(1)(C) of such Act.

(B) EXCEPTION FOR BENEFICIARIES ENROLLED IN RFP PLAN.—

(i) IN GENERAL.—In no case shall an individual described in subparagraph (A)(ii) include an individual who is enrolled, pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract.

(ii) RFP CONTRACT DESCRIBED.—The RFP contract described in this section is a contract entered into between the Secretary and a sponsor of a prescription drug plan pursuant to the Centers for Medicare & Medicaid Services' request for proposals issued on February 17, 2009, relating to Medicare part D retroactive coverage for certain low income beneficiaries, or a similar subsequent request for proposals.

SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is amended by adding after ''PDP region'' the following: ''or through use of an intelligent assignment process that is designed to maximize the access of such individual to necessary prescription drugs while minimizing costs to such individual and to the program under this part to the greatest extent possible. In the case the Secretary enrolls such individuals through use of an intelligent assignment process, such process shall take into account the extent to which prescription drugs necessary for the individual are covered in the case of a PDP sponsor of a prescription drug plan that uses a formulary, the use of prior authorization or other restrictions on access to coverage of such prescription drugs by such a sponsor, and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for contract years beginning with 2012.

SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.

(a) SPECIAL ENROLLMENT PERIOD.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended to read as follows:

''(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.''.

(b) AUTOMATIC ENROLLMENT.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the assignment process described in subparagraph (C) to such individual in the same manner as such assignment process applies to a part D eligible individual described in such subparagraph (C). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidy determinations made for months beginning with January 2011.

SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO REBATE AND QUALITY BONUS PAYMENTS IN CALCULATION OF LOW INCOME SUBSIDY BENCHMARK.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting before the period the following: ''before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved and, in the case of a qualifying plan in a qualifying county, before the application of the increase under section 1853(o) for that plan and year involved''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to subsidy determinations made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(F) The extent to which providers under parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make available language services for beneficiaries with limited English proficiency.

(G) The nature and type of language services provided by States under title XIX of the Social Security Act and the extent to which such services could be utilized by beneficiaries and providers under title XVIII of such Act.

(H) The extent to which interpreters and translators providing services to Medicare beneficiaries under title XVIII of such Act are trained or accredited.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in paragraph (2)(A) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors or agencies, or both);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

(5) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act''), shall not apply for purposes of carrying out this subsection.

(6) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $2,000,000 for purposes of carrying out this subsection.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking ''or'' at the end of subparagraph (F);

(2) by adding ''or'' at the end of subparagraph (G); and

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

''(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;''.

SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Not later than 6 months after the date of the completion of the study described in section 1221(a) of this Act, the Secretary, acting through the Centers for Medicare & Medicaid Services and the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration the Secretary shall take into consideration the results of the study conducted under section 1221(a) of this Act and adjust, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are in the greatest need of language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

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

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) at least 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) at least 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) at least 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) variations in languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions, as defined by the Secretary; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for

the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (e).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than ''very well'' from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of such individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of limited English proficient individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e) and may be modified annually at the discretion of the Secretary. If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery;

(2) ensure the linguistic competence of bilingual providers;

(3) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(4) notify Medicare beneficiaries of their right to receive language services in their primary language;

(5) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(6) ensure that—

(A) primary language data are collected for recipients of language services and are consistent with standards developed under section 1709(b)(3)(B)(iv) of the Public Health Service Act, as added by section 2402 of this Act, to the extent such standards are available upon the initiation of the demonstration; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. Each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(8) An account of the training or accreditation of bilingual staff, interpreters, or translators providing services under this demonstration.

(f) NO COST SHARING.—Limited English proficient Medicare beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) The extent to which bilingual staff, interpreters, and translators providing services under such demonstration were trained or accredited and the nature of accreditation or training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to subsection (c) of section 1907 of this Act.

(4) Recommendations, if any, regarding the extension of such project to the entire Medicare program.

(h) ACCREDITATION OR TRAINING FOR PROVIDERS OF INTERPRETATION, TRANSLATION OR LANGUAGE SERVICES IN MEDICARE.—

(1) IN GENERAL.—

(A) DESIGNATION OF STANDARDS.—If the Secretary, pursuant to section 1907(c) of this Act, expands the model initially developed through the demonstration program under this section, the Secretary shall use the results of the study under section 1221 and the demonstration under this section to designate standards for training or accreditation. The Secretary may designate one or more training or accreditation organizations, as appropriate for the nature and type of interpretation and translation services provided to Medicare beneficiaries to ensure that payments are made only for approved services by trained or accredited language services providers.

(B) ALTERNATIVES TO TRAINING OR ACCREDITATION.—If the Secretary designates one or more training or accreditation organizations but determines that accreditation is not available in all languages for which payments may be initiated, the Secretary shall provide payments for and accept alternatives to training or accreditation for certain languages, including languages of lesser diffusion. The Secretary must ensure that the alternatives to training or accreditation provide, at a minimum—

(i) a determination that the interpreter is proficient and able to communicate information accurately in both English and in the language for which interpreting is needed;

(ii) an attestation from the interpreter to comply with and adhere to the role of an interpreter as defined by the National Code of Ethics and National Standards of Practice as published by the National Council on Interpreting in Health Care; and

(iii) an attestation to adhere to HIPAA privacy and security law, as defined in section 3009(a)(2) of the Public Health Service Act, to the same extent as the healthcare provider for whom interpreting is provided.

(C) MODIFIERS, ADD-ONS, AND OTHER FORMS OF PAYMENT.—If the Secretary decides that modifiers, add-ons, or other forms of payment may be made for the provision of services directly by bilingual providers, the Secretary shall designate standards to ensure the competency of such providers delivering such services in a non-English language.

(2) CONSULTATION WITH STAKEHOLDERS AND CONSIDERATIONS FOR ACCREDITATION OR TRAINING.—

(A) CONSULTATION.—In designating accreditation or training requirements under this subsection, the Secretary shall consult with

patients, providers, organizations that advocate on behalf of limited English proficient individuals, and other individuals or entities determined appropriate by the Secretary.

(B) CONSIDERATIONS.—In designating accreditation or training requirements under this section, the Secretary shall consider, as appropriate—

(i) standards for qualifications of health care interpreters who interpret infrequently encountered languages;

(ii) standards for qualifications of health care interpreters who interpret in languages of lesser diffusion;

(iii) standards for training of interpreters; and

(iv) standards for continuing education of interpreters.

(i) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(j) APPROPRIATIONS.—There are appropriated to carry out this section, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $16,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 1224. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term ''bilingual'' with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term ''competent interpreter services'' means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term ''competent translation services'' means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term ''effective communication'' means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms ''interpreting'' and ''interpretation'' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term ''health care services'' means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term ''health care-related services'' means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term ''language access'' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term ''language services'' means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term ''limited English proficient'' or ''LEP'' with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title.

(12) MEDICARE PROGRAM.—The term ''Medicare program'' means the programs under parts A through D of title XVIII of the Social Security Act.

(13) SERVICE PROVIDER.—The term ''service provider'' includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

Subtitle C—Miscellaneous Improvements

SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS PROCESS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' before '', with the thirty-sixth month''.

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1395o) is amended—

(i) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.—Every individual who''; and

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

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

''(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.''.

(C) TECHNICAL AMENDMENT TO CORRECT DUPLICATE SUBSECTION DESIGNATION.—Subsection (c) of section 226A of such Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.''.

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of such Act is further amended—

(1) in subsection (b)(14)(B)(iii), by inserting '', including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics),'' after ''other drugs and biologicals'';

(2) in subsection (b)(14)(E)(ii)—

(A) in the first sentence—

(i) by striking ''a one-time election to be excluded from the phase-in'' and inserting ''an election, with respect to 2011, 2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)''; and

(ii) by adding before the period at the end the following: ''for such year and for each subsequent year during the phase-in described in clause (i)''; and

(B) in the second sentence—

(i) by striking ''January 1, 2011'' and inserting ''the first date of such year''; and

(ii) by inserting ''and at a time'' after ''form and manner''; and

(3) in subsection (h)(4)(E), by striking ''lesser'' and inserting ''greater''.

SEC. 1233. VOLUNTARY ADVANCE CARE PLANNING CONSULTATION.

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

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraph (DD);

(B) by adding ''and'' at the end of subparagraph (EE); and

(C) by adding at the end the following new subparagraph:

''(FF) voluntary advance care planning consultation (as defined in subsection (hhh)(1));''; and

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

''Voluntary Advance Care Planning Consultation

''(hhh)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

''(A) An explanation by the practitioner of advance care planning, including a review of key questions and considerations, advance directives (including living wills and durable powers of attorney) and their uses.

''(B) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(C) An explanation by the practitioner of physician orders regarding life sustaining treatment or similar orders, in States where such orders or similar orders exist.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatments, such as a nurse practitioner or physician assistant).

''(3) An individual may receive the voluntary advance care planning care planning consultation provided for under this subsection no more than once every 5 years unless there is a significant change in the health or health-related condition of the individual.

''(4) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that effectively communicates the individual's preferences regarding life sustaining treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.''.

(b) CONSTRUCTION.—The voluntary advance care planning consultation described in section 1861(hhh) of the Social Security Act, as added by subsection (a), shall be completely optional. Nothing in this section shall—

(1) require an individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document;

(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title; or

(3) encourage the promotion of suicide or assisted suicide.

(c) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ''(2)(FF),'' after ''(2)(EE),''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(hhh)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to consultations furnished on or after January 1, 2011.

SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF LIMITED ENROLLMENT PENALTY FOR TRICARE BENEFICIARIES.

(a) PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls or, at the option of the individual, on the first day of the second month following the last month of the individual's initial enrollment period.

''(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrollment period described in paragraph (2).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made on or after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—

(1) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendment made by paragraph (1) shall apply with respect to elections made on or after the date of the enactment of this Act.

(B) REBATES FOR CERTAIN DISABLED AND ESRD BENEFICIARIES.—

(i) IN GENERAL.—With respect to premiums for months on or after January 2005 and before the month of the enactment of this Act, no increase in the premium shall be effected for a month in the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act under section 226(b) or 226A of such Act, and who is eligible to enroll, but who has elected not to enroll (or to be deemed enrolled), during the individual's initial enrollment period, and who enrolls under this part within the 12-month period that begins on the first day of the month after the month of notification of entitlement under this part.

(ii) CONSULTATION WITH DEPARTMENT OF DEFENSE.—The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in this paragraph.

(iii) REBATES.—The Secretary of Health and Human Services shall establish a method for providing rebates of premium increases paid for months on or after January 1, 2005, and before the month of the enactment of this Act for which a penalty was applied and collected.

SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX YEAR IN CASE OF GAINS FROM SALE OF PRIMARY RESIDENCE IN COMPUTING PART B INCOME-RELATED PREMIUM.

(a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II)) is amended by inserting ''sale of primary residence,'' after ''divorce of such individual,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums and payments for years beginning with 2011.

SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT DECISIONS AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall establish a shared decision making demonstration program (in this subsection referred to as the ''program'') under the Medicare program using patient decision aids to meet the objective of improving the understanding by Medicare beneficiaries of their medical treatment options, as compared to comparable Medicare beneficiaries who do not participate in a shared decision making process using patient decision aids.

(b) SITES.—

(1) ENROLLMENT.—The Secretary shall enroll in the program not more than 30 eligible providers who have experience in implementing, and have invested in the necessary infrastructure to implement, shared decision making using patient decision aids.

(2) APPLICATION.—An eligible provider seeking to participate in the program shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(3) PREFERENCE.—In enrolling eligible providers in the program, the Secretary shall give preference to eligible providers that—

(A) have documented experience in using patient decision aids for the conditions identified by the Secretary and in using shared decision making;

(B) have the necessary information technology infrastructure to collect the information required by the Secretary for reporting purposes; and

(C) are trained in how to use patient decision aids and shared decision making.

(c) FOLLOW-UP COUNSELING VISIT.—

(1) IN GENERAL.—An eligible provider participating in the program shall routinely schedule Medicare beneficiaries for a counseling visit after the viewing of such a patient decision aid to answer any questions

the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their medical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits provided to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services; and

(B) of a single payment amount for such service that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eligible provider such as would be made under the applicable payment systems to that provider for similar covered services.

(d) COSTS OF AIDS.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider's practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of health care services, and on improving the quality of life of such beneficiaries.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term ''eligible provider'' means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids.

(2) PATIENT DECISION AID.—The term ''patient decision aid'' means an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

(3) SHARED DECISION MAKING.—The term ''shared decision making'' means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as added by section 1152(f), the following new section:

''ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

''SEC. 1866E. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a pilot program (in this section referred to as the 'pilot program') to test different payment incentive models, including (to the extent practicable) the specific payment incentive models described in subsection (c), designed to reduce the growth of expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (e)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

''(A) promote accountability for a patient population and coordinate items and services under parts A and B (and may include Part D, if the Secretary determines appropriate);

''(B) encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and

''(C) reward physician practices and other physician organizational models for the provision of high quality and efficient health care services.

''(2) SCOPE.—The Secretary shall set specific goals for the number of accountable care organizations, participating practitioners, and patients served in the initial tests under the pilot program to ensure that the pilot program is of sufficient size and scope to—

''(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

''(B) subject to subsection (g)(1), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a qualifying accountable care organization model to be successful in improving quality and reducing costs, the Secretary shall seek to implement such models on as large a geographic scale as practical and economical.

''(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOS).—

''(1) QUALIFYING ACO DEFINED.—In this section:

''(A) IN GENERAL.—The terms 'qualifying accountable care organization' and 'qualifying ACO' mean a group of physicians or other physician organizational model (as defined in subparagraph (D)) that—

''(i) is organized at least in part for the purpose of providing physicians' services; and

''(ii) meets such criteria as the Secretary determines to be appropriate to participate in the pilot program, including the criteria specified in paragraph (2).

''(B) INCLUSION OF OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Nothing in this subsection shall be construed as preventing a qualifying ACO from including a hospital or any other provider of services or supplier furnishing items or services for which payment may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

''(C) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services under this title.

''(D) OTHER PHYSICIAN ORGANIZATIONAL MODEL.—The term 'other physician organization model' means, with respect to a qualifying ACO any model of organization under which physicians enter into agreements with other providers of services for the purposes of participation in the pilot program in order to provide high quality and efficient health care services and share in any incentive payments under such program

''(E) OTHER SERVICES.—Nothing in this paragraph shall be construed as preventing a qualifying ACO from furnishing items or services, for which payment may not be made under this title, for purposes of achieving performance goals under the pilot program.

''(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for an organized group of physicians to be a qualifying ACO:

''(A) The group has a legal structure that would allow the group to receive and distribute incentive payments under this section.

''(B) The group includes a sufficient number of primary care physicians (regardless of specialty) for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary).

''(C) The group reports on quality measures in such form, manner, and frequency as specified by the Secretary (which may be for the group, for providers of services and suppliers, or both).

''(D) The group reports to the Secretary (in a form, manner and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the pilot program.

''(E) The group provides notice to applicable beneficiaries regarding the pilot program (as determined appropriate by the Secretary).

''(F) The group contributes to a best practices network or website, that shall be maintained by the Secretary for the purpose of sharing strategies on quality improvement, care coordination, and efficiency that the groups believe are effective.

''(G) The group utilizes patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring of ongoing care management plan.

''(H) The group meets other criteria determined to be appropriate by the Secretary.

''(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The specific payment incentive models described in this subsection are the following:

''(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the 'performance target model'):

''(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if expenditures for items and services for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment shall be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B (and may include Part D, if the Secretary determines appropriate).

''(B) COMPUTATION OF PERFORMANCE TARGET.—

''(i) IN GENERAL.—The Secretary shall establish a performance target for each qualifying ACO comprised of a base amount (described in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established on a per capita basis or adjusted for risk, as the Secretary determines to be appropriate.

''(ii) BASE AMOUNT.—For purposes of clause (i), the base amount in this subparagraph is equal to the average total payments (or allowed charges) under parts A and B (and may include part D, if the Secretary determines appropriate) for applicable beneficiaries for whom the qualifying ACO furnishes items and services in a base period determined by the Secretary. Such base amount may be determined on a per capita basis or adjusted for risk.

''(iii) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the period of the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries (as determined by the Secretary).

''(iv) REBASING.—Under this model the Secretary shall periodically rebase the base expenditure amount described in clause (ii).

''(C) MEETING TARGET.—

''(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meets or exceeds annual quality and performance targets for a year shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year are estimated to be below the performance target for such year, as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

''(ii) LIMITATION.—The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this section were not implemented.

''(D) REPORTING AND OTHER REQUIREMENTS.—In carrying out such model, the Secretary may (as the Secretary determines to be appropriate) incorporate reporting requirements, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

''(2) PARTIAL CAPITATION MODEL.—

''(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a 'partial capitation model') is a model in which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B (and may include part D, if the Secretary determines appropriate), such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to a qualifying ACO for items and services under this title for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

''(3) OTHER PAYMENT MODELS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

''(d) ANNUAL QUALITY TARGETS.—

''(1) IN GENERAL.—The Secretary shall establish annual quality targets that qualifying ACOs must meet to receive incentive payments, operate at financial risk, or otherwise participate in alternative financing models under this section. The Secretary shall establish a process for developing annual targets based on ACO reporting of multiple quality measures. In selecting measures the Secretary shall—

''(A) for years one and two of each ACOs participation in the pilot program established by this section, require reporting of a starter set of measures focused on clinical care, care coordination and patient experience of care; and

''(B) for each subsequent year, require reporting of a more comprehensive set of clinical outcomes measures, care coordination measures and patient experience of care measures.

''(2) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures that reflect national priorities for quality improvement and patient-centered care consistent with the measures developed under section 1192(c)(1).

''(e) APPLICABLE BENEFICIARIES.—

''(1) IN GENERAL.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying ACO, an individual who—

''(A) is enrolled under part B and entitled to benefits under part A;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

''(C) meets such other criteria as the Secretary determines appropriate, which may include criteria relating to frequency of contact with physicians in the ACO

''(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying ACO.

''(f) IMPLEMENTATION.—

''(1) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

''(2) WAIVER.—The Secretary may waive such provisions of this title (including section 1877) and title XI in the manner the Secretary determines necessary in order implement the pilot program.

''(3) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results to qualifying ACOs under the pilot program at least annually.

''(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the elements, parameters, scope, and duration of the pilot program;

''(B) the selection of qualifying ACOs for the pilot program;

''(C) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings;

''(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

''(E) decisions about the extension of the program under subsection (h), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

''(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(g) EVALUATION; MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

''(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the 'Stark law').

''(h) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

''(1) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter for six years, the Secretary shall submit to Congress and make publicly available a report on the use of ACO payment models under the pilot program. Each report shall address the impact of the use of those models on expenditures, access, and quality under this title.

''(2) EXTENSION.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate if—

''(A) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or

''(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

''(3) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

''(i) EXPANSION TO ADDITIONAL ACOS.—

''(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE MODELS.—Subject to the evaluation described in subsection (g), the Secretary may enter into agreements under the pilot program with additional qualifying ACOs to further test and refine payment incentive models with respect to qualifying ACOs.

''(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, 1 or more models if, and to the extent that, such models are beneficial to the program under this title, as determined by the Secretary.

''(B) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall certify that 1 or more of such models described in subparagraph (A) would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

''(j) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—

''(1) EXTENSION.—The Secretary may enter in to an agreement with a qualifying ACO under the demonstration under section

1866A, subject to rebasing and other modifications deemed appropriate by the Secretary, until the pilot program under this section is operational.

''(2) TRANSITION.—For purposes of extension of an agreement with a qualifying ACO under subsection (h)(2), the Secretary shall treat receipt of an incentive payment for a year by an organization under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such subsection, as long as such practice group practice organization meets the criteria under subsection (b)(2).

''(k) ADDITIONAL PROVISIONS.—

''(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect variation in average annual attributable expenditures and other matters the Secretary deems appropriate.

''(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organizations under the pilot program, the Secretary may limit a qualifying ACO's exposure to high cost patients under the program.

''(3) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

''(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(5) FUNDING.—For purposes of administering and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c)(1), in addition to funds otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of fiscal years 2010 through 2014 and $20,000,000 for fiscal year 2015. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

''(6) NO DUPLICATION IN PAYMENTS TO PHYSICIANS IN MULTIPLE PILOTS.—The Secretary shall not make payments under this section to any physician group that is paid under section 1866F (relating to medical homes) or section 1866G (relating to independence at home).''.

SEC. 1302. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866E, as inserted by section 1301, the following new section:

''MEDICAL HOME PILOT PROGRAM

''SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

''(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the 'pilot program') for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to beneficiaries (as defined in subsection (b)(4)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

''(2) SCOPE.—Subject to subsection (g), the Secretary shall set specific goals for the number of practices and communities, and the number of patients served, under the pilot program in the initial tests to ensure that the pilot program is of sufficient size and scope to—

''(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

''(B) subject to subsection (e)(1), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a medical home model to be successful in improving quality and reducing costs, the Secretary shall implement such model on as large a geographic scale as practical and economical.

''(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

''(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

''(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

''(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

''(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the nurse practitioner is acting in a manner that is consistent with State law.

''(B) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the physician assistant is acting in a manner that is consistent with State law.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'patient-centered medical home services' means services that—

''(A) provide beneficiaries with direct and ongoing access to a primary care or principal care physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

''(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, provider of services, and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

''(C) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified physicians or providers for all stages of life;

''(D) provide continuous access to care and communication with participating beneficiaries;

''(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

''(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

''(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

''(2) PRIMARY CARE.—The term 'primary care' means health care that is provided by a physician, nurse practitioner, or physician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

''(3) PRINCIPAL CARE.—The term 'principal care' means integrated, accessible health care that is provided by a physician who is a medical specialist or subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the specialist's or subspecialist's expertise, and for whom the specialist or subspecialist assumes care management.

''(4) BENEFICIARIES.—The term 'beneficiaries' means, with respect to a qualifying medical home, an individual who—

''(A) is enrolled under part B and entitled to benefits under part A;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

''(C) meets such other criteria as the Secretary determines appropriate.

''(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

''(1) IN GENERAL.—

''(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3) for targeted high need beneficiaries (as defined in subparagraph (C)).

''(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term 'independent patient-centered medical home' means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

''(i) providing beneficiaries with patient-centered medical home services; and

''(ii) meets such other requirements as the Secretary may specify.

''(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term 'targeted high need beneficiary' means a beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

''(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

''(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 12 months after the date of the enactment of this section and shall operate for 5 years.

''(2) QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall establish a process for practices to qualify as medical homes.

''(3) PAYMENT.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

''(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

''(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

''(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

''(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

''(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified health centers, and rural health centers.

''(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

''(1) IN GENERAL.—

''(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the 'CBMH model'), the Secretary shall make payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for beneficiaries.

''(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term 'community-based medical home' means a nonprofit community-based or State-based organization or a State that is certified under paragraph (2) as meeting the following requirements:

''(i) The organization provides beneficiaries with medical home services.

''(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary as his or her community-based medical home provider.

''(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, nutritional counseling, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

''(iv) The organization meets such other requirements as the Secretary may specify.

''(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process to provide for the review and qualification of community-based medical homes pursuant to criteria established by the Secretary.

''(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under paragraph (6).

''(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary shall give preference to applications which seek to eliminate health disparities, as defined in section 3171 of the Public Health Service Act and may give preference to any of the following:

''(A) Applications that propose to coordinate health care items and services under this title for chronically ill beneficiaries who rely, for primary care, on small physician or nurse practitioner practices, federally qualified health centers, rural health clinics, or other settings with limited resources and scope of services.

''(B) Applications that include other third-party payors that furnish medical home services for chronically ill patients covered by such third-party payors.

''(C) Applications from States that propose to use the medical home model to coordinate health care services for—

''(i) individuals enrolled under this title;

''(ii) individuals enrolled under title XIX; and

''(iii) full-benefit dual eligible individuals (as defined in section 1935(c)(6)),

with chronic diseases across a variety of health care settings.

''(5) PAYMENTS.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each beneficiary who consents to receive medical home services through such medical home, as follows:

''(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization or State.

''(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

''(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

''(D) AMOUNT OF PAYMENT.—In determining the amount of such payment under subparagraph (B), the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing the medical home services provided by the primary or principal care practice (such as providing increased access, care coordination, care planning, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

''(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

''(iii) In the case of the models described in subparagraphs (B) and (C) of paragraph (4), the Secretary may determine an appropriate payment amount.

''(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a non-profit community based or State-based organization or a State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes how such funds will be used. The Secretary shall select a territory of the United States as one of the locations in which to implement the pilot program under this subsection, unless no organization in a territory is able to comply with the requirements under paragraph (1)(B).

''(e) EXPANSION OF PROGRAM.—

''(1) EVALUATION OF COST AND QUALITY.—The Secretary shall evaluate the pilot program to determine—

''(A) the extent to which medical homes result in—

''(i) improvement in the quality and coordination of items and services under this title, particularly with regard to the care of complex patients;

''(ii) improvement in reducing health disparities;

''(iii) reductions in preventable hospitalizations;

''(iv) prevention of readmissions;

''(v) reductions in emergency room visits;

''(vi) improvement in health outcomes, including patient functional status where applicable;

''(vii) improvement in patient satisfaction;

''(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

''(ix) reductions in health care expenditures; and

''(B) the feasability and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

''(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1) and the extent to which standards for the certification of medical homes need to be periodically updated.

''(3) EXPANSION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

''(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

''(C) UPDATED STANDARDS.—The Secretary shall periodically review and update the standards for qualification as an independent patient centered medical home and as a community based medical home and shall establish a process for ensuring that medical homes meet such updated standards, as applicable

''(f) ADMINISTRATIVE PROVISIONS.—

''(1) NO DUPLICATION IN PAYMENTS FOR INDIVIDUALS IN MEDICAL HOMES.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

''(2) NO EFFECT ON PAYMENT FOR MEDICAL VISITS.—Payments made under this section are in addition to, and have no effect on the amount of, payment for medical visits made under this title

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(4) NO DUPLICATION IN PHYSICIAN PILOT PARTICIPATION.—The Secretary shall not

make payments to an independent or community based medical home both under this section and section 1866E or 1866G, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

''(5) WAIVER.—The Secretary may waive such provisions of this title and title XI in the manner the Secretary determines necessary in order to implement this section.

''(g) FUNDING.—

''(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

''(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

''(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

''(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

''(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

''(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

''(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount provided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as added by section 133 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

''(2) Notwithstanding section 1302(c) of the Affordable Health Care for America Act, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

(c) CONFORMING REPEAL.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as amended by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is repealed.

SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 1833 of the Social Security Act is amended by inserting after subsection (o) the following new subsection:

''(p) PRIMARY CARE PAYMENT INCENTIVES.—

''(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner (as defined in paragraph (3)) for which amounts are payable under section 1848, in addition to the amount otherwise paid under this part there shall also be paid to the practitioner (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a primary care health professional shortage area.

''(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term 'primary care services'—

''(A) mean evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under this title) for—

''(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

''(ii) preventive services (as defined in section 1861(iii) for which payment is made under this section; and

''(B) includes services furnished by another health care professional that would be described in subparagraph (A) if furnished by a physician.

''(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term 'primary care practitioner'—

''(A) means a physician or other health care practitioner (including a nurse practitioner) who—

''(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

''(ii) has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

''(B) includes a physician assistant who is under the supervision of a physician described in subparagraph (A).

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

''(A) any determination or designation under this subsection;

''(B) the identification of services as primary care services under this subsection; and

''(C) the identification of a practitioner as a primary care practitioner under this subsection.

''(5) COORDINATION WITH OTHER PAYMENTS.—

''(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

''(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1834(g)(2)(B).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

''(4) The provisions of this subsection shall not be taken into account in applying subsections (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.''.

(2) Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting '', (p),'' after ''(m)''.

(3) Section 1848(o)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting ''primary care'' before ''health professional shortage area''.

SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking ''(but in no event'' and all that follows through ''performed by a physician)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) MEDICARE COVERED PREVENTIVE SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 1233(a)(1)(B), is amended by adding at the end the following new subsection:

''Medicare Covered Preventive Services

''(iii)(1) Subject to the succeeding provisions of this subsection, the term 'Medicare covered preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp).

''(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

''(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

''(H) Diabetes screening tests (as defined in subsection (yy)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

''(J) Federally approved and recommended vaccines and their administration as described in subsection (s)(10).

''(K) Screening mammography (as defined in subsection (jj)).

''(L) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

''(M) Bone mass measurement (as defined in subsection (rr)).

''(N) Kidney disease education services (as defined in subsection (ggg)).

''(O) Additional preventive services (as defined in subsection (ddd)).

''(2) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.''.

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) IN GENERAL.—

(A) IN GENERAL.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by adding after and below paragraph (9) the following:

''With respect to Medicare covered preventive services, in any case in which the payment rate otherwise provided under this part

is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.''.

(B) APPLICATION TO SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(i) in paragraph (2)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''; and

(ii) in paragraph (3)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''screening mammography (as defined in section 1861(jj)) and diagnostic mammography'' and inserting ''diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(iii)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (G), by adding ''and'' at the end; and

(iii) by adding at the end the following new subparagraph:

''(H) with respect to additional preventive services (as defined in section 1861(ddd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);''.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''Medicare covered preventive services (as defined in section 1861(iii))'';

(B) by inserting ''and'' before ''(4)''; and

(C) by striking clauses (5) through (8).

(4) APPLICATION TO PROVIDERS OF SERVICES.—Section 1866(a)(2)(A)(ii) of such Act (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting ''other than for Medicare covered preventive services and'' after ''for such items and services (''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

(d) PREVENTIVE SERVICES.—

(1) REPORT TO CONGRESS ON BARRIERS TO PREVENTIVE SERVICES.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit to abdominal aortic aneurysm screening and other preventative services through the Welcome to Medicare Physical Exam.

(2) ABDOMINAL AORTIC ANEURYSM SCREEN ACCESS.—The Secretary shall, to the extent practical, identify and implement policies promoting proper use of abdominal aortic aneurysm screening among Medicare beneficiaries at risk for such aneurysms.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 1305(b), is further amended—

(1) in subsection (a), in the sentence added by section 1305(b)(1)(A), by inserting ''(including services described in the last sentence of section 1833(b))'' after ''preventive services''; and

(2) in subsection (b), by adding at the end the following new sentence: ''Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.

SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2010.

SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 1235, is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(GG) marriage and family therapist services (as defined in subsection (jjj));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 1233 and 1305, is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(jjj)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' before ''(W)''; and

(ii) by inserting before the semicolon at the end the following: '', and (X) with respect to marriage and family therapist services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A HEALTH CARE PROFESSIONAL.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician or nurse practitioner in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a), is amended by inserting ''marriage and family therapist services (as defined in subsection (jjj)(1)),'' after ''clinical social worker services,''.

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (jjj)(2)),''.

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A marriage and family therapist (as defined in section 1861(jjj)(2)).''.

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as previously amended, is further amended—

(A) in subparagraph (FF), by striking ''and'' at the end;

(B) in subparagraph (GG), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(HH) mental health counselor services (as defined in subsection (kkk)(1));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as previously amended, is amended by adding at the end the following new subsection:

''Mental Health Counselor Services

''(kkk)(1) The term 'mental health counselor services' means services performed by a

mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking ''and'' at the end of clause (iv);

(B) by adding ''and'' at the end of clause (v); and

(C) by adding at the end the following new clause:

''(vi) mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is further amended—

(i) by striking ''and'' before ''(X)''; and

(ii) by inserting before the semicolon at the end the following: '', and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a) and subsection (a), is amended by inserting ''mental health counselor services (as defined in section 1861(kkk)(1)),'' after ''marriage and family therapist services (as defined in subsection (jjj)(1)),''.

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a), is amended by striking ''or by a marriage and family therapist (as defined in subsection (jjj)(2)),'' and inserting ''by a marriage and family therapist (as defined in subsection (jjj)(2)), or a mental health counselor (as defined in subsection (kkk)(2)),''.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

''(viii) A mental health counselor (as defined in section 1861(kkk)(2)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

''(10) federally approved and recommended vaccines (as defined in subsection (lll)) and their respective administration;''.

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

''Federally Approved and Recommended Vaccines

''(lll) The term 'federally approved and recommended vaccine' means a vaccine that—

''(1) is licensed under section 351 of the Public Health Service Act, approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

''(2) is recommended by the Director of the Centers for Disease Control and Prevention.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking ''1861(s)(10)(A)'' and inserting ''1861(s)(10)'' each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking ''subparagraph (A) or (B) of''; and

(B) by inserting before the period the following: ''and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011''.

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting '', including a vaccine furnished on or after January 1, 2010''; and

(B) by the following new paragraph:

''(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) or subsection (f)(2) for purposes of implementation of this section.''.

(4) Section 1860D–2(e)(1) of such Act (42 U.S.C. 1395w–102(e)(1)) is amended by striking ''such term includes a vaccine'' and all that follows through ''its administration) and''.

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking ''Pneumococcal, influenza, and hepatitis B vaccine and administration'' and inserting ''federally approved or authorized vaccines (as defined in subsection (lll)) and their respective administration''.

(6) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting ''(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),'' after ''described in subparagraph''.

(7) Section 1847A(f) of such Act (42 U.S.C. 1395w–3a(f)) is amended—

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

(B) by indenting paragraph (1), as redesignated in subparagraph (A), 2 ems to the left; and—

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

''(2) TREATMENT OF CERTAIN MANUFACTURERS.—In the case of a manufacturer of a drug or biological described in subparagraphs (A)(iv), (C), (D), (E), or (G) of section 1842(o)(1) that does not have a rebate agreement under section 1927(a), no payment may be made under this part for such drug or biological if such manufacturer does not submit the information described in section 1927(b)(3)(A)(iii) in the same manner as if the manufacturer had such a rebate agreement in effect. Subparagraphs (C) and (D) of section 1927(b)(3) shall apply to information reported pursuant to the previous sentence in the same manner as such subparagraphs apply with respect to information reported pursuant to such section.''.''.

(d) EFFECTIVE DATES.—The amendments made—

(1) by this section (other than by subsection (c)(6)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(6) shall apply to calendar quarters beginning on or after January 1, 2010.

SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

''(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and services described in section 1861(iii); and''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply not later than January 1, 2011.

SEC. 1312. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866F, as inserted by section 1302, the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

''SEC. 1866G. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

''(A) reducing preventable hospitalizations;

''(B) preventing hospital readmissions;

''(C) reducing emergency room visits;

''(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

''(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

''(F) reducing the cost of health care services covered under this title; and

''(G) achieving beneficiary and family caregiver satisfaction.

''(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

''(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

''(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

''(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

''(ii) is organized at least in part for the purpose of providing physicians' services;

''(iii) has documented experience in providing home-based primary care services to high cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) includes at least 200 applicable beneficiaries as defined in subsection (d);

''(v) has entered into an agreement with the Secretary;

''(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

''(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

''(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

''(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

''(A) all the requirements of this section are met;

''(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

''(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

''(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

''(4) QUALITY AND PERFORMANCE STANDARDS.—

''(A) IN GENERAL.—An independence at home medical practice participating in the demonstration program shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

''(B) DEVELOPMENT OF QUALITY PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

''(c) SHARED SAVINGS PAYMENT METHODOLOGY.—

''(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish annual target spending levels for items and services covered under parts A and B furnished to applicable beneficiaries by qualifying independence at home medical practices under this section. The Secretary may set an aggregate target spending level for all qualifying practices, or may set different target spending levels for groups of practices or a single practice. Such target spending levels may be determined on a per capita basis and shall take into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries. The target shall also be adjusted for the size of the practice, number of practices included in the target spending level, characteristics of applicable beneficiaries and such other factors as the Secretary determines appropriate. The Secretary may periodically adjust or rebase the target spending level under this paragraph.

''(2) SHARED SAVINGS AMOUNTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), qualifying independence at home medical practices are eligible to receive an incentive payment under this section if aggregate expenditures for a year for applicable beneficiaries are less than the target spending level for qualifying independence at home medical practices for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which total payments for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the target spending level for such year, as determined by the Secretary.

''(B) APPORTIONMENT OF SAVINGS.—The Secretary shall designate how, and to what extent, an incentive payment under this section is to be apportioned among qualifying independence at home medical practices, taking into account the size of the practice, characteristics of the individuals enrolled in each practice, performance on quality performance measures, and such other factors as the Secretary determines appropriate.

''(3) SAVINGS TO THE MEDICARE PROGRAM.—The Secretary shall limit incentive payments to each qualifying independence at home medical practice under this paragraph, with respect to a year, as necessary to ensure that the aggregate expenditures for items and services under parts A and B with respect to applicable beneficiaries for such independence at home medical practice (inclusive of shared savings payments) do not exceed the amount that the Secretary estimates would be expended for such items and services for such beneficiaries during such year (taking into account normal variation in expenditures and other factors the Secretary deems appropriate) if the demonstration program under this section were not implemented, minus 5 percent.

''(d) APPLICABLE BENEFICIARIES.—

''(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

''(A) is entitled to benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

''(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

''(D) within the past 12 months has had a nonelective hospital admission;

''(E) within the past 12 months has received acute or subacute rehabilitation services;

''(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

''(G) meets such other criteria as the Secretary determines appropriate.

''(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

''(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The demonstration program shall begin not later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

''(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1866D or section 1866E.

''(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1866D or section 1866E.

''(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

''(A) located in high-cost areas of the country;

''(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

''(C) use electronic medical records, health information technology, and individualized plans of care.

''(5) NUMBER OF PRACTICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall enter into agreements with as many independence at home medial practices as practicable and consistent with this subsection to test the potential of the independence at home medical practice model under this section in order to achieve the results described in subsection (a) across practices serving varying numbers of applicable beneficiaries.

''(B) LIMITATION.—In selecting qualified independence at home medial practices to participate under the demonstration program, the Secretary shall limit the number of applicable beneficiaries that may participate in the demonstration program to 10,000.

''(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(f) EVALUATION AND MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

''(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

''(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

''(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and shared savings under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

''(i) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program unless such entity guarantees that for individuals eligible to be enrolled in such program, the entity will not deny, limit, or condition the coverage or provision of benefits to which the individual would have otherwise been entitled to on the basis of health status if not included in this program.

''(j) TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice if such practice does not receive incentive payments under subsection (c)(2) or consistently fails to meet quality standards.''.

SEC. 1313. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDICARE DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding at the end the following new part:

''PART D—COMPARATIVE EFFECTIVENESS RESEARCH

''COMPARATIVE EFFECTIVENESS RESEARCH

''SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

''(1) IN GENERAL.—The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

''(2) DUTIES.—The Center shall—

''(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

''(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

''(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

''(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

''(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for highly credible research;

''(F) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

''(G) appoint clinical perspective advisory panels for research priorities under this section, which shall consult with patients and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

''(3) POWERS.—

''(A) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Center, the head of such department or agency shall furnish that information to the Center on an agreed upon schedule.

''(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

''(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

''(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(iii) adopt procedures allowing any interested party to submit information for the use by the Center in making reports and recommendations.

In carrying out clause (ii), the Center may award grants or contracts (or provide for intergovernmental transfers, as applicable) to private entities and governmental agencies with experience in conducting comparative effectiveness research, such as the National Institutes of Health and other relevant Federal health agencies.

''(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

''(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

''(b) COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

''(1) IN GENERAL.—There is established an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to advise the Center and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

''(2) DUTIES.—The Commission shall—

''(A)(i) recommend to the Center national priorities for research described in subsection (a) which shall take into account—

''(I) disease incidence, prevalence, and burden in the United States;

''(II) evidence gaps in terms of clinical outcomes;

''(III) variations in practice, delivery, and outcomes by geography, treatment site, provider type, disability, variation in age group (including children, adolescents, adults, and seniors), racial and ethnic background, gender, genetic and molecular subtypes, and other appropriate populations or subpopulations; and

''(IV) the potential for new evidence concerning certain categories, health care services, or treatments to improve patient health and well-being, and the quality of care; and

''(ii) in making such recommendations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

''(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative effectiveness research recommended to be a national priority under subparagraph (A);

''(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

''(D) review the methodologies developed by the center under subsection (a)(2)(C);

''(E) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

''(F) make recommendations to the Center for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

''(G) make recommendations to the Center for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

''(H) at least annually review the processes of the Center and make reports to Congress and the President regarding research conducted, supported, or synthesized by the Center to confirm that the information produced by such research is objective, credible, consistent with standards of evidence developed under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

''(I) make recommendations to the Center for the broad dissemination, consistent with subsection (e), of the findings of research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value; and

''(J) at least twice each year, hold a public meeting with an opportunity for stakeholder input.

The reports under subparagraph (H) shall not be submitted to the Office of Management and Budget or to any other Federal agency or executive department for any purpose prior to transmittal to Congress and the President. Such reports shall be published on the public internet website of the Commission after the date of such transmittal.

''(3) COMPOSITION OF COMMISSION.—

''(A) IN GENERAL.—The members of the Commission shall consist of—

''(i) the Director of the Agency for Healthcare Research and Quality or their designee;

''(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services or their designee;

''(iii) the Director of the National Institutes of Health or their designee; and

''(iv) 16 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, and consumers of Federal and State beneficiary programs.

Of such members, at least 10 shall be practicing physicians, health care practitioners, consumers, or patients.

''(B) QUALIFICATIONS.—

''(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

''(I) Epidemiology.

''(II) Health services research.

''(III) Bioethics.

''(IV) Decision sciences.

''(V) Health disparities.

''(VI) Health economics.

''(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

''(I) Patients.

''(II) Health care consumers.

''(III) Practicing Physicians, including surgeons.

''(IV) Other health care practitioners engaged in clinical care.

''(V) Organizations with proven expertise in racial and ethnic minority health research.

''(VI) Employers.

''(VII) Public payers.

''(VIII) Insurance plans.

''(IX) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

''(C) LIMITATION.—No more than 3 of the Members of the Commission may be representatives of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(IX).

''(4) APPOINTMENT.—The Comptroller General shall appoint the members of the Commission.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term. The Chairman shall serve as an ex officio member of the National Advisory Council of the Agency for Health Care Research and Quality under section 931(c)(3)(B) of the Public Health Service Act.

''(6) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

''(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(i) 8 shall be appointed for a term of 4 years; and

''(ii) 8 shall be appointed for a term of 3 years.

''(7) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

''(8) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(A) appoint and set the compensation for an Executive Director (subject to the approval of the Comptroller General) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Commission;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(9) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable the Commission to carry out this section. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish the information to the Commission on an agreed upon schedule.

''(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(11) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

''(12) CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall take into consideration any financial interest (as defined in subparagraph (D)), consistent with this paragraph, and develop a plan for managing any identified conflicts.

''(B) EVALUATION AND CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(iii) for service on the Commission at a meeting of the Commission.

''(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

''(i) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) regarding a 'particular matter' (as that term is used in section 208 of title 18, United States Code), each member of the Commission or the clinical perspective advisory panel who is a full-time

Government employee or special Government employee shall disclose to the Comptroller General or Secretary, respectively, financial interests in accordance with requiring a waiver under section 208(b) of title 18, United States Code, or other interests as deemed relevant by the Secretary.

''(ii) PROHIBITIONS ON PARTICIPATION.—Except as provided under clause (iii), a member of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if such member has a financial interest that could be affected by the advice given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the Government officers or employees to which such regulations apply.

''(iii) WAIVER.—If the Comptroller General or Secretary, as applicable, determines it necessary to afford the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) essential expertise, the Comptroller General or Secretary, respectively, may grant a waiver of the prohibition in clause (ii) to permit a member described in such subparagraph to—

''(I) participate as a non-voting member with respect to a particular matter considered in a meeting of the Commission or a clinical perspective advisory panel, respectively; or

''(II) participate as a voting member with respect to a particular matter considered in a meeting of the Commission.

''(iv) LIMITATION ON WAIVERS AND OTHER EXCEPTIONS.—

''(I) DETERMINATION OF ALLOWABLE EXCEPTIONS FOR THE COMMISSION.—The number of waivers granted to members of the Commission cannot exceed one-half of the total number of members for the Commission.

''(II) PROHIBITION ON VOTING STATUS ON CLINICAL PERSPECTIVE ADVISORY PANELS.—No voting member of any clinical perspective advisory panel shall be in receipt of a waiver. No more than two nonvoting members of any clinical perspective advisory panel shall receive a waiver.

''(D) FINANCIAL INTEREST DEFINED.—For purposes of this paragraph, the term 'financial interest' means a financial interest under section 208(a) of title 18, United States Code.

''(13) APPLICATION OF FACA.—The Federal Advisory Committee Act (other than section 14 of such Act) shall apply to the Commission to the extent that the provisions of such Act do not conflict with the requirements of this subsection.

''(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

''(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

''(A) The establishment of a research agenda by the Center shall be informed by the national priorities for research recommended under subsection (b)(2)(A).

''(B) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

''(C) Methods of conducting such research shall be scientifically based.

''(D) Consistent with applicable law, all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

''(E) Consistent with applicable law, the process and methods for conducting such research shall be publicly documented and available to all stakeholders.

''(F) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

''(G) Such research shall consider advice given to the Center by the clinical perspective advisory panel for the particular national research priority.

''(2) STAKEHOLDER INPUT.—

''(A) IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission.

''(B) SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—

''(i) recommending research priorities and questions;

''(ii) recommending research methodologies; and

''(iii) advising on and assisting with efforts to disseminate research findings.

''(C) OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—

''(i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center; and

''(ii) ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Center.

''(3) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

''(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items, services, and systems used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), individuals with disabilities, and individuals with different comorbidities and genetic and molecular subtypes; and—

''(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

''(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

''(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by the Center or a grantee or contractor of the Center:

''(A) Any interim or progress reports as deemed appropriate by the Secretary.

''(B) Stakeholder comments.

''(C) A final report.

''(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, relevant expert organizations (as defined in subsection (i)(3)(A)), and Federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

''(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions;

''(B) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate;

''(C) include considerations such as limitations of research and what further research may be needed, as appropriate;

''(D) not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and

''(E) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

''(2) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Center shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting such protocols and strategies, the Center shall consult with stakeholders concerning the types of dissemination that will be most useful to the end users of information and may provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.

''(f) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality shall submit to Congress an annual report on the activities of the Center, as well as the research, conducted under this section. Each such report shall include a discussion of the Center's compliance with subsection (c)(3)(B), including any reasons for lack of compliance with such subsection.

''(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

''(3) ANALYSIS AND REVIEW.—Not later than December 31, 2013, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Center but not funded.

''(g) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available in accordance with such section, without the need for further appropriations and without fiscal year limitation, to carry out this section.

''(h) CONSTRUCTION.—

''(1) COVERAGE.—Nothing in this section shall be construed—

''(A) to permit the Center or Commission to mandate coverage, reimbursement, or other policies for any public or private payer; or

''(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

''(2) REPORTS AND FINDINGS.—None of the reports submitted under this section or research findings disseminated by the Center or Commission shall be construed as mandates, for payment, coverage, or treatment.

''(3) PROTECTING THE PHYSICIAN-PATIENT RELATIONSHIP.—Nothing in this section shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine.

''(i) CONSULTATION WITH RELEVANT EXPERT ORGANIZATIONS.—

''(1) CONSULTATION PRIOR TO INITIATION OF RESEARCH.—Prior to recommending priorities or initiating research described in this section, the Commission or the Center shall consult with the relevant expert organizations responsible for standards and protocols of clinical excellence. Such consultation shall be consistent with the processes established under subsection (c)(2).

''(2) CONSULTATION IN DISSEMINATION OF RESEARCH.—Any dissemination of research from the Commission or the Center and findings made by the Commission or the Center shall be consistent with processes established under subsection (e) and shall—

''(A) be based upon evidence-based medicine; and

''(B) take into consideration standards and protocols of clinical excellence developed by relevant expert organizations.

''(3) DEFINITIONS.—For purposes of this subsection:

''(A) RELEVANT EXPERT ORGANIZATIONS.—The term 'relevant expert organization' means an organization with expertise in the rigorous application of evidence-based scientific methods for the design of clinical studies, the interpretation of clinical data, and the development of national clinical practice guidelines, including a voluntary health organization, clinical specialty, or other professional organization that represents physicians based on the field of medicine in which each such physician practices or is board certified.

''(B) STANDARDS AND PROTOCOLS OF CLINICAL EXCELLENCE.—The term 'standards and protocols of clinical excellence' means clinical or practice guidelines that consist of a set of directions or principles that is based on evidence and is designed to assist a health care practitioner with decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances.

''(j) RESEARCH MAY NOT BE USED TO DENY OR RATION CARE.—Nothing in this section shall be construed to make more stringent or otherwise change the standards or requirements for coverage of items and services under this Act.''.

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR THE TRUST FUND.—For the provision establishing a Comparative Effectiveness Research Trust Fund and financing such Trust Fund, see section 1802.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES, NURSING FACILITIES, AND OTHER LONG-TERM CARE FACILITIES

SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility (as defined in paragraph (6)(B)) shall have the information described in paragraph (3) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 1411(b) of the Affordable Health Care for America Act, for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (4)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

''(2) PUBLIC AVAILABILITY OF INFORMATION.—During the period described in paragraph (1)(A), a facility shall—

''(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

''(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

''(3) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) A description of the organizational structure and the relationship of each person and entity described in subclauses (II) and (III) of clause (ii) to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such Form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(4) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate regulations requiring a facility to report the information described in paragraph (3) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such regulations shall specify the frequency of reporting, as determined by the Secretary. Such final regulations shall also require—

''(i) the reporting of such information on or after the first day of the first calendar quarter beginning after the date that is 90 days after the date on which such final regulations are published in the Federal Register; and—

''(ii) the certification, as a condition of participation under the program under title XVIII or XIX, that such information is accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(5) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

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

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who, through ownership interest, partnership interest, contract, or otherwise—

''(i) directly or indirectly exercises operational, financial, administrative, or managerial control or direction over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property;

''(iii) lends funds or provides a financial guarantee to the facility in an amount which is equal to or exceeds $50,000; or

''(iv) provides management or administrative services, clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(4)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the information reported in accordance with such final regulations shall be made available to the public in accordance with procedures established by the Secretary of Health and Human Services.

(c) CONFORMING AMENDMENTS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

SEC. 1412. ACCOUNTABILITY REQUIREMENTS.

(a) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 1411(c)(1), is amended by adding at the end the following new subparagraph:

''(C) COMPLIANCE AND ETHICS PROGRAMS.—

''(i) REQUIREMENT.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which regulations developed under clause (ii) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

''(ii) DEVELOPMENT OF REGULATIONS.—

''(I) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subparagraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multiunit nursing home chains.

''(III) EVALUATION.—Not later than 3 years after the date on which compliance and ethics programs established under this subparagraph are in operation pursuant to clause (i), the Secretary shall complete an evaluation of such programs. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a skilled nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a skilled nursing facility in lieu of section 1874(d).''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

''(C) COMPLIANCE AND ETHICS PROGRAM.—

''(i) REQUIREMENT.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which regulations developed under clause (ii) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

''(iii) DEVELOPMENT OF REGULATIONS.—

''(I) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subparagraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multiunit nursing home chains.

''(III) EVALUATION.—Not later than 3 years after the date on which compliance and ethics programs established under this subparagraph are in operation pursuant to clause (i), the Secretary shall complete an evaluation of such programs. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(v) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(vi) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and has sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(vii) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(77).''.

(b) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) SKILLED NURSING FACILITIES.—Section 1819(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A skilled nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation;

(C) in clause (i) (as so designated by subparagraph (B)), by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively; and

(D) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for skilled nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a skilled nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(2) NURSING FACILITIES.—Section 1919(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation; and

(C) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(3) PROPOSAL TO REVISE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—The Secretary shall implement policies that modify and strengthen quality assurance and performance improvement programs in skilled nursing facilities and nursing facilities on a periodic basis, as determined by the Secretary.

(4) FACILITY PLAN.—Not later than 1 year after the date on which the regulations are promulgated under subclause (II) of clause (ii) of sections 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to meet the standards under such regulations and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i) of such sections.

(c) GAO STUDY ON NURSING FACILITY UNDERCAPITALIZATION.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities, taking into account ownership type (including private equity and control interests), are undercapitalizing such facilities.

(B) The effects of such undercapitalization on quality of care, including staffing and food costs, at such facilities.

(C) Options to address such undercapitalization, such as requirements relating to surety bonds, liability insurance, or minimum capitalization.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) NURSING FACILITY.—In this subsection, the term ''nursing facility'' includes a skilled nursing facility.

SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Information that is reported to the Secretary under section 1124(c)(4).

''(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare and Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

''(I) were newly enrolled in the program;

''(II) are enrolled in the program and have failed to significantly improve;

''(III) are enrolled in the program and have significantly improved;

''(IV) have graduated from the program; and

''(V) have closed voluntarily or no longer participate under this title.

''(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(v) The standardized complaint form developed under subsection (f)(8), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

''(viii) The number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (iv) identifying information on complainants or residents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification recommendation made respecting a skilled nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having a poor compliance history or that substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Information that is reported to the Secretary under section 1124(c)(4)

''(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare & Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

''(I) were newly enrolled in the program;

''(II) are enrolled in the program and have failed to significantly improve;

''(III) are enrolled in the program and have significantly improved;

''(IV) have graduated from the program; and

''(V) have closed voluntarily or no longer participate under this title.

''(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C)(ii), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(v) The standardized complaint form developed under subsection (f)(10), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury.

''(viii) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (ii) identifying information about complainants or residents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing

Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification recommendation made respecting a nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of such Act is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having a poor compliance history or that substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

''(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

''(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

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

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is no more than two years after the redesign of the report specified in subparagraph (2), skilled nursing facilities shall—

''(A) separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff); and

''(B) take into account agency and contract staff in a manner to be determined by the Administrator.

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 2 years after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Beginning with cost reports submitted under paragraph (1) , the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall categorize the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 1415. STANDARDIZED COMPLAINT FORM.

(a) SKILLED NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(a)(3), is amended by adding at the end the following new paragraph:

''(9) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a skilled nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1819(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

''(6) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(9) available upon request to—

''(i) a resident of a skilled nursing facility;

''(ii) any person acting on the resident's behalf; and

''(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the skilled nursing facility, that the legal representative of a resident of a skilled nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A skilled nursing facility may not file a complaint or a report against a person who works (or has worked at the facility) with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

''(iii) RELIEF.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain all appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

''(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(9) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(b) NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1919(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(b), is amended by adding at the end the following new paragraph:

''(11) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

''(8) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

''(i) a resident of a nursing facility;

''(ii) any person acting on the resident's behalf; and

''(iii) any person who works at a nursing facility or a representative of such a worker.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a resident of a nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(11) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(11) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

''(iii) RELIEF.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain all appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

''(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(11) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.

(a) SKILLED NURSING FACILITIES.—Section 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—On and after the first day of the first calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a skilled nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract

staff shall be kept separate from information on employee staffing.''.

(b) NURSING FACILITIES.—Section 1919(b)(8) of the Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—On and after the first day of the first calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 1417. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). The Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsections (b)(3)(A) and (b)(6), respectively, of such section 307. The program under this subsection shall contain the following modifications to such pilot program:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were not otherwise required to be conducted by such long-term care facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1);

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were not otherwise required to be conducted by such long-term care facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal or other background checks on the prospective employee through such means as the Secretary determines appropriate that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation; and

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal or other background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

Background checks and screenings under this subsection shall be valid for a period of no longer than 2 years, as determined by the State and approved by the Secretary.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i).

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i).

(6) DEFINITIONS.—Under the nationwide program:

(A) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a nursing home level of care conveyed by State licensure or State definition.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(B) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program. Such evaluation shall include—

(i) a review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

(ii) an assessment of the costs of conducting such background checks (including start-up and administrative costs);

(iii) a determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

(iv) an assessment of the impact of the program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable; and

(v) an evaluation of other aspects of the program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section, including costs for the Department of Health and Human Services to administer and evaluate the program, for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

PART 2—TARGETING ENFORCEMENT

SEC. 1421. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term 'applicable per instance amount' means—

''(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

''(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

''(III) APPLICABLE PER DAY AMOUNT.—In this clause, the term 'applicable per day amount' means—

''(aa) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

''(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

''(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in subclause (II)(bb).

''(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

''(aa) subject to item (cc), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established by the State survey agency, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for

the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii),''after ''(i),''.

(b) NURSING FACILITIES.—

(1) PENALTIES IMPOSED BY THE STATE.—

(A) IN GENERAL.—Section 1919(h)(2) of the Social Security Act (42 U.S.C. 1396r(h)(2)) is amended—

(i) in subparagraph (A)(ii), by striking the first sentence and inserting the following: ''A civil money penalty in accordance with subparagraph (G).''; and

(ii) by adding at the end the following new subparagraph:

''(G) CIVIL MONEY PENALTIES.—

''(i) IN GENERAL.—The State may impose a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(ii) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term 'applicable per instance amount' means—

''(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

''(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

''(iii) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term 'applicable per day amount' means—

''(I) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

''(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

''(iv) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

''(v) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

''(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(II) or (iii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

''(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (iv) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(vi) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

''(I) subject to subclause (III), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established by the State survey agency, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(II) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under subclause (I) is completed;

''(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subclause (I) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(V) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(VI) in the case where all such appeals are unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).''.

(B) CONFORMING AMENDMENT.—The second sentence of section 1919(h)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', and some portion of such funds may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, providing technical assistance to facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary)''.

(2) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITION ON REDUCTION FOR REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

''(aa) subject to item (bb), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same

manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) CONFORMING AMENDMENT.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''and in paragraph (3)(C)(ii)'' after ''paragraph (2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the ''pilot program'') to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program based on criteria selected by the Secretary, including where evidence suggests that one or more facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes one or more facilities participating in the ''Special Focus Facility'' program (or a successor program) or one or more facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES OF THE INDEPENDENT MONITOR.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of such program shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of the chain and the principal business partners of such owners in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after the date of receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State (or States) involved, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the pilot program. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the pilot program.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(2) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program. Such evaluation shall—

(A) determine whether the independent monitor program should be established on a permanent basis; and

(B) if the Inspector General determines that the independent monitor program should be established on a permanent basis, recommend appropriate procedures and mechanisms for such establishment.

(2) REPORT.—Not later than 180 days after the completion of the pilot program, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended by adding at the end the following new paragraph:

''(7) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is the administrator of a skilled nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.''.

(2) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(A) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to subsection (c)(7), shall terminate''; and

(B) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''paragraphs (2) and (7) of subsection (c)''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1396r(c)) is amended by adding at the end the following new paragraph:

''(9) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that

has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(b) NURSING FACILITIES.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISORY STAFF.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities. The study shall include an analysis of the following:

(A) Whether the number of initial training hours for certified nurse aides required under sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(II); 1396r(f)(2)(A)(i)(II)) should be increased from 75 and, if so, what the required number of initial training hours should be, including any recommendations for the content of such training (including training related to dementia).

(B) Whether requirements for ongoing training under such sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) should be increased from 12 hours per year, including any recommendations for the content of such training.

(2) CONSULTATION.—In conducting the analysis under paragraph (1)(A), the Secretary shall consult with States that, as of the date of the enactment of this Act, require more than 75 hours of training for certified nurse aides.

(3) DEFINITIONS.—In this section:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 1433. QUALIFICATION OF DIRECTOR OF FOOD SERVICES OF A SKILLED NURSING FACILITY OR NURSING FACILITY.

(a) MEDICARE.—Section 1819(b)(4)(A) of the Social Security Act (42 U.S.C. 1395i–3(b)(4)(A)) is amended by adding at the end the following: ''With respect to meeting the staffing requirement imposed by the Secretary to carry out clause (iv), the full-time director of food services of the facility, if not a qualified dietitian (as defined in section 483.35(a)(2) of title 42, Code of Federal Regulations, as in effect as of the date of the enactment of this sentence), shall be a Certified Dietary Manager meeting the requirements of the Certifying Board for Dietary Managers, or a Dietetic Technician, Registered meeting the requirements of the Commission on Dietetic Registration or have equivalent military, academic, or other qualifications (as specified by the Secretary).''.

(b) MEDICAID.—Section 1919(b)(4)(A) of the Social Security Act (42 U.S.C. 1396r(b)(4)(A)) is amended by adding at the end the following: ''With respect to meeting the staffing requirement imposed by the Secretary to carry out clause (iv), the full-time director of food services of the facility, if not a qualified dietitian (as defined in section 483.35(a)(2) of title 42, Code of Federal Regulations, as in effect as of the date of the enactment of this sentence), shall be a Certified Dietary Manager meeting the requirements of the Certifying Board for Dietary Managers, or a Dietetic Technician, Registered meeting the requirements of the Commission on Dietetic Registration or have equivalent military, academic, or other qualifications (as specified by the Secretary).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 180 days after the date of enactment of this Act.

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

''PART E—QUALITY IMPROVEMENT

''ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

''SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

''(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

''(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

''(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic diseases;

''(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

''(3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care, including those due to variations in care;

''(4) address health disparities across groups and areas; and

''(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

''(d) DEFINITIONS.—In this part:

''(1) CONSENSUS-BASED ENTITY.—The term 'consensus-based entity' means an entity with a contract with the Secretary under section 1890.

''(2) QUALITY MEASURE.—The term 'quality measure' means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

''(e) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

Part E of title XI of the Social Security Act, as added by section 1441, is amended by adding at the end the following new sections:

''SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.

''(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

''(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

''(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

''(3) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

''(A) seek public input; and

''(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

''(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

''(c) DEVELOPMENT OF QUALITY MEASURES.—

''(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—In entering into agreements under subsection (a), the Secretary shall give priority to the development of quality measures that allow the assessment of—

''(A) health outcomes, presence of impairment, and functional status of patients;

''(B) the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

''(C) patient experience and patient engagement;

''(D) the safety, effectiveness, and timeliness of care;

''(E) health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language; and

''(F) the efficiency and resource use in the provision of care.

''(2) USE OF FUNDS.—An entity that enters into an agreement under subsection (a) shall develop quality measures that—

''(A) to the extent feasible, have the ability to be collected through the use of health information technologies supporting better delivery of health care services; and

''(B) are available free of charge to users for the use of such measures.

''(3) AVAILABILITY OF MEASURES.—The Secretary shall make quality measures developed under this section available to the public.

''(4) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.

''(5) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the updating (and testing, if applicable) by consensus-based entities of quality measures that have been previously endorsed by such an entity as new evidence is developed, in a manner consistent with section 1890(b)(3).

''(d) QUALIFIED ENTITIES.—Before entering into agreements with a qualified entity, the Secretary shall ensure that the entity is a public, private, or academic institution with technical expertise in the area of health quality measurement.

''(e) APPLICATION FOR GRANT.—A grant may be made under this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(f) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $25,000,000, to the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $25,000,000 for each of the fiscal years 2010 through 2014.

''SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

''(a) GAO EVALUATIONS.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

''(b) CONSIDERATIONS.—In carrying out the evaluation under subsection (a), the Comptroller General shall determine—

''(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;

''(2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients' personal health information and provides data security;

''(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and

''(4) the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.

''(c) REPORT.—The Comptroller General shall submit reports to Congress and to the Secretary containing a description of the findings and conclusions of the results of each such evaluation.''.

SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

''(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.—

''(1) LIST OF MEASURES.—Not later than December 1 before each year (beginning with 2011), the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the calendar year following such year, as the case may be.

''(2) CONSULTATION ON SELECTION OF ENDORSED QUALITY MEASURES.—A consensus-based entity that has entered into a contract under section 1890 shall, as part of such contract, convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in public health care programs.

''(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.

''(4) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (2) with respect to the selection of quality measures, the consensus-based entity described in such paragraph shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under paragraph (2) shall ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection.

''(5) USE OF INPUT.—The respective proposed rule shall contain a summary of the recommendations made by the multi-stakeholder groups under paragraph (2), as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

''(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

''(A) Hospitals and other institutional providers.

''(B) Physicians.

''(C) Health care quality alliances.

''(D) Nurses and other health care practitioners.

''(E) Health plans.

''(F) Patient advocates and consumer groups.

''(G) Employers.

''(H) Public and private purchasers of health care items and services.

''(I) Labor organizations.

''(J) Relevant departments or agencies of the United States.

''(K) Biopharmaceutical companies and manufacturers of medical devices.

''(L) Licensing, credentialing, and accrediting bodies.

''(7) FUNDING.—

''(A) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.

''(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this subsection, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1444. APPLICATION OF QUALITY MEASURES.

(a) INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

''(x)(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, the quality measures specified under clause (viii) shall be measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(b) OUTPATIENT HOSPITAL SERVICES.—Section 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is amended by adding at the end the following new subparagraph:

''(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1886(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to quality measures for inpatient hospital services.''.

(c) PHYSICIANS' SERVICES.—Section 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w–4(k)(2)(C)(ii)) is amended by adding at the end the following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(d) RENAL DIALYSIS SERVICES.—Section 1881(h)(2)(B)(ii) of such Act (42 U.S.C. 1395rr(h)(2)(B)(ii)) is amended by adding at the end the following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(e) ENDORSEMENT OF STANDARDS.—Section 1890(b)(2) of the Social Security Act (42 U.S.C. 1395aaa(b)(2)) is amended by adding after and below subparagraph (B) the following:

''If the entity does not endorse a measure, such entity shall explain the reasons and provide suggestions about changes to such measure that might make it a potentially endorsable measure.''.

(f) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.

SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by striking ''for each of fiscal years 2009 through 2012'' and inserting ''for fiscal year 2009, and $12,000,000 for each of the fiscal years 2010 through 2012''.

SEC. 1446. QUALITY INDICATORS FOR CARE OF PEOPLE WITH ALZHEIMER'S DISEASE.

(a) QUALITY INDICATORS.—The Secretary of Health and Human Services shall develop quality indicators for the provision of medical services to people with Alzheimer's disease and other dementias and a plan for implementing the indicators to measure the quality of care provided for people with these conditions by physicians, hospitals, and other appropriate providers of services and suppliers.

(b) REPORT.—The Secretary shall submit a report to the Committees on Energy and Commerce and Ways and Means of the United States House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the United States Senate not later than 24 months after the date of the enactment of this Act setting forth the status of their efforts to implement the requirements of subsection (a).

Subtitle D—Physician Payments Sunshine Provision

SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BETWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND PHYSICIANS AND OTHER HEALTH CARE ENTITIES AND BETWEEN PHYSICIANS AND OTHER HEALTH CARE ENTITIES.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 1631(a), is further amended by inserting after section 1128G the following new section:

''SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS' FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND WITH ENTITIES THAT BILL FOR SERVICES UNDER MEDICARE.

''(a) REPORTING OF PAYMENTS OR OTHER TRANSFERS OF VALUE.—

''(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011, and annually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier.

''(B) With respect to the payment or other transfer of value, other than a drug sample—

''(i) its value and date;

''(ii) the name of the related drug, device, or supply, if available, to the level of specificity available; and

''(iii) a description of its form, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form (as defined by the Secretary).

''(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

''(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

''(3) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

''(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENTS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor pursuant to a product development agreement for services furnished in connection with the development of a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

''(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report as required under this section in the next reporting period under this subsection after the earlier of the following:

''(A) The date that the clinical investigation is registered on the website maintained by the National Institutes of Health pursuant to section 671 of the Food and Drug Administration Amendments Act of 2007.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until or after the date on which the information is made available to the public under such paragraph.

''(7) PHYSICIANS IN SELF-INSURED HEALTH PLANS.—Nothing in this subsection shall be construed to require the disclosure of a payment or other transfer of value to a physician by a self-insured health plan.

''(b) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS.—

''(1) HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization) that bills the Secretary under part A or part B of title XVIII for services shall report on the ownership shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity.

''(2) ADDITIONAL PHYSICIAN OWNERSHIP.—Not later than March 31 of each year (beginning with 2011), in addition to the requirement under subsection (a)(1), any applicable manufacturer, applicable group purchasing organization, or applicable distributor shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer, applicable group purchasing organization or applicable distributor during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (iii) of paragraph (a)(1)(B), and information described in subsection (f)(8)(A) and (f)(8)(B).

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

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

''(A) PHYSICIAN.—The term 'physician' includes a physician's immediate family members (as defined for purposes of section 1877(a)).

''(B) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means any organization or other entity (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply.

''(4) STUDY OF PRACTICE PATTERNS IN ADVANCED DIAGNOSTIC IMAGING AND RADIATION ONCOLOGY SERVICES.—The Comptroller General of the United States shall conduct a study to evaluate the extent of use of physician self-referral arrangements and the effects of such arrangements on the cost of

providing advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries under title XVIII. The study shall be completed and submitted to Congress not later than July 1, 2011.

''(c) PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—The Secretary shall establish procedures to ensure that, not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under subsections (a) and (b), other than information regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

''(A) is searchable and is in a format that is clear and understandable;

''(B) contains information that is presented by the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(C) contains information that is able to be easily aggregated and downloaded;

''(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year;

''(E) contains background information on industry-physician relationships;

''(F) in the case of information submitted with respect to a payment or other transfer of value described in subsection (a)(5), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(G) contains any other information the Secretary determines would be helpful to the average consumer; and

''(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

''(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the reporting entity reporting under subsection (a) or (b), as applicable. The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the applicable reporting entity with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

''(3) SPECIAL RULE FOR DRUG SAMPLES.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(4) SPECIAL RULE FOR NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(d) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any reporting entity that fails to submit information required under subsection (a) or (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A), with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any reporting entity that knowingly fails to submit information required under subsection (a) or (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) or (b) by an applicable reporting entity shall not exceed $1,000,000, or, if greater, 0.1 percentage of the total annual revenues of the reporting entity.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary of an intent to proceed under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against an applicable manufacturer or distributor in the State.

''(e) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

''(1) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

''(2) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE DISTRIBUTOR.—The term 'applicable distributor' means—

''(A) any entity, other than an applicable group purchasing organization, that buys and resells, or receives a commission or other similar form of payment, from another seller, for selling or arranging for the sale of a covered drug, device, biological, or medical supply; or

''(B) any entity under common ownership with such an entity described in subparagraph (A) and which provides assistance or support to such entity so described with respect to the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.

Such term does not include a wholesale pharmaceutical distributor.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, processing, marketing, or manufacturer-direct distribution of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity and which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution or a covered drug, device, biological, or medical supply). For purposes of this section only, such term does not include a retail pharmacy licensed under State law.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered' means, with respect to a drug, device, biological, or medical supply, such a drug, device, biological, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(5) COVERED RECIPIENT.—The term 'covered recipient' means the following:

''(A) A physician.

''(B) A physician group practice.

''(C) Any other prescriber of a covered drug, device, biological, or medical supply.

''(D) A pharmacy or pharmacist.

''(E) A health insurance issuer, group health plan, or other entity offering a health benefits plan, including any employee of such an issuer, plan, or entity.

''(F) A pharmacy benefit manager, including any employee of such a manager.

''(G) A hospital.

''(H) A medical school.

''(I) A sponsor of a continuing medical education program.

''(J) A patient advocacy or disease specific group.

''(K) A organization of health care professionals.

''(L) A biomedical researcher.

''(M) A group purchasing organization.

''(6) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(7) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(8) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value for or of any of the following:

''(i) Gift, food, or entertainment.

''(ii) Travel or trip.

''(iii) Honoraria.

''(iv) Research funding or grant.

''(v) Education or conference funding.

''(vi) Consulting fees.

''(vii) Ownership or investment interest and royalties or license fee.

''(B) INCLUSIONS.—Subject to subparagraph (C), the term 'payment or other transfer of value' includes any compensation, gift, honorarium, speaking fee, consulting fee, travel, services, dividend, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a

manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

''(C) EXCLUSIONS.—The term 'payment or other transfer of value' does not include the following:

''(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed $5.

''(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(iii) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(v) In-kind items used for the provision of charity care.

''(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(vii) Compensation paid by an applicable manufacturer or distributor to a covered recipient who is directly employed by and works solely for such manufacturer or distributor.

''(viii) Payments made to a covered recipient by an applicable manufacturer or by a health plan affiliated with an applicable manufacturer for medical care provided to employees of such manufacturer or their dependents.

''(ix) Any discount (including a rebate).

''(x) Any payment or other transfer of value that is made to a covered recipient indirectly through an entity other than the applicable manufacturer in connection with an activity or service—

''(I) in which the applicable manufacturer is unaware of the identity of the covered recipient and is not using such activity or service to market its product to the covered recipient; and

''(II) that is not designed to market or promote the product to the covered recipient.

''(xi) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

''(9) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(10) REPORTING ENTITY.—The term 'reporting entity' means—

''(A) with respect to the reporting requirement under subsection (a), an applicable manufacturer or distributor of a covered drug, device, biological, or medical supply required to report under such subsection; and

''(B) with respect to the reporting requirement under subsection (b), a hospital, other health care entity, applicable manufacturer, applicable distributor, or applicable group purchasing organization required to report physician ownership under such subsection.

''(g) ANNUAL REPORTS TO STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to States a report that includes a summary of the information submitted under subsections (a), (b), and (e) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

''(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any statute or regulation of a State or political subdivision of a State that requires any of the following:

''(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

''(B) The disclosure or reporting, in any format, of information described in subsection (f)(8)(C), except in the case of information described in clause (i) of subsection (f)(8)(C).

''(C) The disclosure or reporting, in any format, of the type of information by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (f)).

''(D) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

Nothing in paragraph (1) shall be construed to limit the discovery or admissibility of information described in this paragraph in a criminal, civil, or administrative proceeding.''.

(b) AVAILABILITY OF INFORMATION FROM THE DISCLOSURE OF FINANCIAL RELATIONSHIP REPORT (DFRR).—The Secretary of Health and Human Services shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required pursuant to section 5006 of the Deficit Reduction Act of 2005. Such report shall be submitted to Congress not later than the date that is 6 months after the date such surveys are collected and shall be made publicly available on an Internet website of the Department of Health and Human Services.

(c) GAO REPORT.—Not later than December 31, 2012, the Comptroller General of the United States shall submit to Congress a report on section 1128H of the Social Security Act, as added by subsection (a). Such report shall address the extent to which important transfers of value are being adequately reported under such section (including unreported transfers required by such section as well as transfers not required to be reported by such section), the impact on States of the federal preemption provision under subsection (h) of such section, whether changes have occurred in the pattern of payments as a result of efforts to evade reporting requirements, a description of the financial relationships subject to delayed reporting under subsection (a) of such section, and any recommended improvements to the collection or the analysis of data reported under such section.

Subtitle E—Public Reporting on Health Care-Associated Infections

SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1138 the following section:

''SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

''(a) REPORTING REQUIREMENT.—

''(1) IN GENERAL.—The Secretary shall provide that a hospital (as defined in subsection (g)) or ambulatory surgical center meeting the requirements of titles XVIII or XIX may participate in the programs established under such titles only if, in accordance with this section, the hospital or center reports such information on health care-associated infections that develop in the hospital or center (and such demographic information associated with such infections) as the Secretary specifies.

''(2) REPORTING PROTOCOLS.— Such information shall be reported in accordance with reporting protocols established by the Secretary through the Director of the Centers for Disease Control and Prevention (in this section referred to as the 'CDC') and to the National Healthcare Safety Network of the CDC or under such another reporting system of such Centers as determined appropriate by the Secretary in consultation with such Director.

''(3) COORDINATION WITH HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is coordinated with systems established under the HITECH Act, where appropriate.

''(4) PROCEDURES TO ENSURE THE VALIDITY OF INFORMATION.—The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall address failures to report as well as errors in reporting.

''(5) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of CDC, shall promulgate regulations to carry out this section.

''(b) PUBLIC POSTING OF INFORMATION.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

''(1) among hospitals and ambulatory surgical centers; and

''(2) by demographic information.

''(c) ANNUAL REPORT TO CONGRESS.—On an annual basis the Secretary shall submit to the Congress a report that summarizes each of the following:

''(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year.

''(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

''(3) Based on the most recent information available to the Secretary on the composition of the professional staff of hospitals and ambulatory surgical centers, the number of certified infection control professionals on the staff of hospitals and ambulatory surgical centers.

''(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

''(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

''(d) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information on health care-associated infections or patient safety procedures for a hospital or ambulatory surgical center.

''(e) HEALTH CARE-ASSOCIATED INFECTION.—For purposes of this section:

''(1) IN GENERAL.—The term 'health care-associated infection' means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

''(2) RELATED TO RECEIVING HEALTH CARE.—The term 'related to receiving health care', with respect to an infection, means that the infection was not incubating or present at the time health care was provided.

''(f) APPLICATION TO CRITICAL ACCESS HOSPITALS.—For purposes of this section, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).''.

(b) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act (as inserted by subsection (a) of this section), the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) as the Secretary of Health and Human Services shall specify. In order to meet such deadline, the Secretary may implement such section through guidance or other instructions.

(c) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a). Such report shall include an analysis of the appropriateness of the types of information required for submission, compliance with reporting requirements, the success of the validity procedures established, and any conflict or overlap between the reporting required under such section and any other reporting systems mandated by either the States or the Federal Government.

(d) REPORT ON ADDITIONAL DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report on the appropriateness of expanding the requirements under such section to include additional information (such as health care worker immunization rates), in order to improve health care quality and patient safety.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''and paragraph (8)'' after ''this paragraph''; and

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

''(8) ADDITIONAL REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) PROGRAMS SUBJECT TO REDUCTION.—If a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(ii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing residency training program that is not reflected on the most recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident level that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

''(III) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause is the limitation applicable under subclause (I) of such paragraph.

''(IV) PREVIOUS REDISTRIBUTION.—The reference resident level specified in this clause for a hospital shall be increased to the extent required to take into account an increase in resident positions made available to the hospital under paragraph (7)(B) that are not otherwise taken into account under a previous subclause.

''(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and to the extent the hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of available slots accordingly, or which the Secretary otherwise has permitted the resident positions (under section 402 of the Social Security Amendments of 1967) to be aggregated for purposes of applying the resident position limitations under this subsection.

''(B) REDISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The estimated aggregate number of increases in the otherwise applicable resident limit under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

''(ii) REQUIREMENTS FOR QUALIFYING HOSPITALS.—A hospital is not a qualifying hospital for purposes of this paragraph unless the following requirements are met:

''(I) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—The hospital maintains the number of primary care residents at a level that is not less than the base level of primary care residents increased by the number of additional primary care resident positions provided to the hospital under this subparagraph. For purposes of this subparagraph, the 'base level of primary care residents' for a hospital is the level of such residents as of a base period (specified by the Secretary), determined without regard to whether such positions were in excess of the otherwise applicable resident limit for such period but taking into account the application of subclauses (II) and (III) of subparagraph (A)(ii).

''(II) DEDICATED ASSIGNMENT OF ADDITIONAL RESIDENT POSITIONS TO PRIMARY CARE.—The hospital assigns all such additional resident positions for primary care residents.

''(III) ACCREDITATION.—The hospital's residency programs in primary care are fully accredited or, in the case of a residency training program not in operation as of the base year, the hospital is actively applying for such accreditation for the program for such additional resident positions (as determined by the Secretary).

''(iii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011, made available under this subparagraph, as determined by the Secretary.

''(iv) PRIORITY FOR CERTAIN HOSPITALS.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall distribute the increase to qualifying hospitals based on the following criteria:

''(I) The Secretary shall give preference to hospitals that had a reduction in resident training positions under subparagraph (A).

''(II) The Secretary shall give preference to hospitals with 3-year primary care residency training programs, such as family practice and general internal medicine.

''(III) The Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

''(IV) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

''(V) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (designated under section 332 of the Public Health Service Act) or a health professional needs area (designated under section 2211 of such Act).

''(VI) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

''(vi) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph not later than July 1, 2011.

''(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

''(i) The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(ii) The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

''(D) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subparagraph (B)—

''(i) to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs; and

''(ii) as a condition of payment for a cost reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

''(I) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(I)) before receiving such additional positions; and

''(II) the number of such additional positions.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the third sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act.''.

SEC. 1502. INCREASING TRAINING IN NONPROVIDER SETTINGS.

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) by designating the first sentence as a clause (i) with the heading ''IN GENERAL.—'' and appropriate indentation;

(2) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(I) effective for cost reporting periods beginning before July 1, 2009, all the time'';

(3) in subclause (I), as inserted by paragraph (1), by striking the period at the end and inserting ''; and''; and

(A) by inserting after subclause (I), as so inserted, the following:

''(II) effective for cost reporting periods beginning on or after July 1, 2009, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009''; and

(2) by inserting after subclause (I), as inserted by paragraph (1), the following new subclause:

''(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.''.

(c) OIG STUDY ON IMPACT ON TRAINING.—The Inspector General of the Department of Health and Human Services shall analyze the data collected by the Secretary of Health and Human Services from the records made available to the Secretary under section 1886(h)(4)(E) of the Social Security Act, as amended by subsection (a), in order to assess the extent to which there is an increase in time spent by medical residents in training in nonprovider settings as a result of the amendments made by this section. Not later than 4 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on such analysis and assessment.

(d) DEMONSTRATION PROJECT FOR APPROVED TEACHING HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under which an approved teaching health center (as defined in paragraph (3)) would be eligible for payment under subsections (h) and (k) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) of amounts for its own direct costs of graduate medical education activities for primary care residents, as well as for the direct costs of graduate medical education activities of its contracting hospital for such residents, in a manner similar to the manner in which such payments would be made to a hospital if the hospital were to operate such a program.

(2) CONDITIONS.—Under the demonstration project—

(A) an approved teaching health center shall contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program of the hospital involved and is responsible for payment to the hospital for the hospital's costs of the salary and fringe benefits for residents in the program;

(B) the number of primary care residents of the center shall not count against the contracting hospital's resident limit; and

(C) the contracting hospital shall agree not to diminish the number of residents in its primary care residency training program.

(3) APPROVED TEACHING HEALTH CENTER DEFINED.—In this subsection, the term ''approved teaching health center'' means a nonprovider setting, such as a Federally qualified health center or rural health clinic (as defined in section 1861(aa) of the Social Security Act), that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking ''Such rules'' and inserting ''Subject to clause (ii), such rules''; and

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

''(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.'';

(2) in paragraph (4), by adding at the end the following new subparagraph:

''(I) TREATMENT OF CERTAIN TIME IN APPROVED MEDICAL RESIDENCY TRAINING PROGRAMING.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 1501(b), is amended by adding at the end the following new clause:

''(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in nonpatient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the

hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2008.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) DIRECT GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—The Secretary shall, by regulation, establish a process consistent with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State closes on or after the date that is 2 years before the date of the enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

''(II) PROCESS FOR HOSPITALS IN CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the State. Such process shall take into consideration the recommendations submitted to the Secretary by the senior health official (as designated by the chief executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital closure involved (or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause, 180 days after such date of enactment).

''(III) LIMITATION.—The estimated aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the estimated number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).''.

(b) NO EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not effect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking ''(7) and'' and inserting ''(4)(H)(vi), (7), and''.

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by inserting ''or under paragraph (4)(H)(vi)'' after ''under this paragraph''.

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with ''Notwithstanding'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with appropriate indentation; and

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

''(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

''(i) Work effectively in various health care delivery settings, such as nonprovider settings.

''(ii) Coordinate patient care within and across settings relevant to their specialties.

''(iii) Understand the relevant cost and value of various diagnostic and treatment options.

''(iv) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

''(v) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in case of such errors, including experience and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

''(vi) Be meaningful EHR users (as determined under section 1848(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.''

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1)(B) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have the appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(A) development of curriculum requirements; and

(B) assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse

SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO FIGHT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $100,000,000 to such Account from such Trust Fund for each fiscal year beginning with 2011. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.''.

(2) in paragraph (4)(A)—

(A) by inserting ''for activities described in paragraph (3)(C) and'' after ''necessary''; and

(B) by inserting ''until expended'' after ''appropriation''.

(b) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (1)(D), by striking all that follows ''in which the person was excluded'' and inserting ''under Federal law from the Federal health care program under which the claim was made, or'';

(2) by striking ''or'' at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end ''or'';

(4) by inserting after paragraph (7) the following new paragraph:

''(8) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;'';

(5) in the matter following paragraph (8), as inserted by paragraph (4), by striking ''or

in cases under paragraph (7), $50,000 for each such act)'' and inserting ''in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (8), $50,000 for each false statement, omission, or misrepresentation of a material fact)''; and

(6) in the second sentence, by striking ''for a lawful purpose)'' and inserting ''for a lawful purpose, or in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF FALSE STATEMENTS MATERIAL TO A FALSE CLAIM.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 1611, is further amended—

(1) in paragraph (7), by striking ''or'' at the end;

(2) in paragraph (8), by inserting ''or'' at the end; and

(3) by inserting after paragraph (8), the following new paragraph:

''(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;''; and

(4) in the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking ''or in cases under paragraph (8)'' and inserting ''in cases under paragraph (8)''; and

(B) by striking ''a material fact)'' and inserting ''a material fact, in cases under paragraph (9), $50,000 for each false record or statement)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking ''or'' at the end;

(2) in paragraph (9), by inserting ''or'' at the end;

(3) by inserting after paragraph (9) the following new paragraph:

''(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(4) in the matter following paragraph (10), as inserted by paragraph (3), by inserting '', or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph'' after ''false record or statement''.

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(1) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(2) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1819 the following new section:

''SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

''(a) IN GENERAL.—If the Secretary determines on the basis of a survey or otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and failed to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

''(1) that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (b)(2)(A); or

''(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may—

''(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

''(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

''(b) INTERMEDIATE SANCTIONS.—

''(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2012—

''(A) a range of intermediate sanctions to apply to hospice programs under the conditions described in subsection (a), and

''(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

''(2) SPECIFIED SANCTIONS.—

''(A) IN GENERAL.—The intermediate sanctions developed under paragraph (1) may include—

''(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000,

''(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

''(iii) the appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made,

''(iv) corrective action plans, and

''(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all requirements referred to in that clause.

''(B) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

''(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

''(3) SECRETARIAL AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.''.

(b) APPLICATION TO MEDICAID.—Section 1905(o) of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

''(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.''.

(c) APPLICATION TO CHIP.—Title XXI of the Social Security Act is amended by adding at the end the following new section:

''SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

''The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner such provisions apply to a hospice program providing hospice care under title XVIII.''.

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking ''or'' at the end of paragraph (9);

(2) by inserting ''or'' at the end of paragraph (10);

(3) by inserting after paragraph (10) the following new paragraph:

''(11) orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or any other item or service, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;''; and

(4) in the matter following paragraph (11), as inserted by paragraph (2), by striking ''$15,000 for each day of the failure described in such paragraph'' and inserting ''$15,000 for each day of the failure described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) IN GENERAL.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D MARKETING VIOLATIONS.

(a) IN GENERAL.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking ''or'' at the end;

(2) by inserting after subparagraph (H) the following new subparagraphs:

''(I) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(J) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(K) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

''(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;''; and

(3) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph.''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) IN GENERAL.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128(c) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking ''AND PERIOD'' and inserting ''PERIOD, AND EFFECT''; and

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

''(4)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

''(i) by an excluded individual or entity; or

''(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

''(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a Federal health care program or to whom such payment was made.

''(C)(i) Payment may be made under a Federal health care program for emergency items or services (not including items or services furnished in an emergency room of a hospital) furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of such individual's exclusion.

''(ii) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for items or services furnished by an excluded individual or entity, and such individual eligible for such benefits did not know or have reason to know that such excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services. In such case the Secretary shall notify such individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

''(iii) In the case that a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than an individual eligible for benefits under title XVIII or XIX or the excluded individual or entity, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant Federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to the individual or entity that submitted the claim for the items or services furnished by the excluded individual or entity. If a Federal health care program contractor provided inaccurate or misleading information that resulted in the waiver of an overpayment under this clause, the Secretary shall take appropriate action to recover the improperly paid amount from the contractor.''.

SEC. 1620. OIG AUTHORITY TO EXCLUDE FROM FEDERAL HEALTH CARE PROGRAMS OFFICERS AND OWNERS OF ENTITIES CONVICTED OF FRAUD.

Section 1128(b)(15)(A) of the Social Security Act (42 U.S.C. 1320a–7(b)(15)(A)) is amended—

(1) in clause (i)—

(A) by striking ''has'' and inserting ''had''; and

(B) by striking ''sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of'' and inserting ''sanctioned entity at the time of, and who knew or should have known (as defined in section 1128A(i)(6)) of,'' ; and

(2) in clause (ii)—

(A) by striking ''is an officer'' and inserting ''was an officer''; and

(B) by inserting before the period the following: ''at the time of the action constituting the basis for the conviction or exclusion described in subparagraph (B)''.

SEC. 1621. SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP''). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to an SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

(d) RELATION TO OTHER LAW AND REGULATION.—Nothing in this section shall affect the application of section 1128G(c) of the Social Security Act, as added by section 1641, except, in the case of a health care provider of services or supplier who is a person (as defined in paragraph (4) of such section 1128G(c)) who discloses an overpayment (as defined in such paragraph) to the Secretary of Health and Human Services pursuant to a SRDP established under this section, the 60-day period described in paragraph (2) of such section 1128G(c) shall be extended with respect to the return of an overpayment to the extent necessary for the Secretary to determine pursuant to the SRDP the amount due and owing.

Subtitle C—Enhanced Program and Provider Protections

SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AUTHORITY.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.

''(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

''(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other sources, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items or services, including a category within a geographic area, under title XVIII, XIX, or XXI, the Secretary may impose any of the following requirements with respect to a provider of services or a supplier (whether such provider or supplier is initially enrolling in the program or is renewing such enrollment):

''(A) Screening under paragraph (2).

''(B) Enhanced oversight periods under paragraph (3).

''(C) Enrollment moratoria under paragraph (4).

In applying this subsection for purposes of title XIX and XXI the Secretary may require a State to carry out the provisions of this subsection as a requirement of the State plan under title XIX or the child health plan under title XXI. Actions taken and determinations made under this subsection shall not be subject to review by a judicial tribunal.

''(2) SCREENING.—For purposes of paragraph (1), the Secretary shall establish procedures under which screening is conducted with respect to providers of services and suppliers described in such paragraph. Such screening may include—

''(A) licensing board checks;

''(B) screening against the list of individuals and entities excluded from the program under title XVIII, XIX, or XXI;

''(C) the excluded provider list system;

''(D) background checks; and

''(E) unannounced pre-enrollment or other site visits.

''(3) ENHANCED OVERSIGHT PERIOD.—For purposes of paragraph (1), the Secretary shall establish procedures to provide for a period of not less than 30 days and not more than 365 days during which providers of services and suppliers described in such paragraph, as the Secretary determines appropriate, would be subject to enhanced oversight, such as required or unannounced (or required and unannounced) site visits or inspections, prepayment review, enhanced review of claims, and such other actions as specified by the Secretary, under the programs under titles XVIII, XIX, and XXI. Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that after the initial period such additional period of oversight is necessary.

''(4) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, may impose a moratorium on the enrollment of providers of services and suppliers within a category of providers of services and suppliers (including a category within a specific geographic area) under such title. Such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

''(5) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—For periods beginning after January 1, 2011, if the Secretary determines under paragraph (1) that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding section 1842(c)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment furnished by such supplier.

''(6) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (23), by inserting before the semicolon at the end the following: ''or by a person to whom or entity to which a moratorium under section 1128G(a)(4) is applied during the period of such moratorium'';

(B) in paragraph (72); by striking at the end ''and'';

(C) in paragraph (73), by striking the period at the end and inserting ''; and''; and

(D) by adding after paragraph (73) the following new paragraph:

''(74) provide that the State will enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection (a) through use of the appropriate procedures described in such subsection (a)), and that the State will carry out any activities as required by the Secretary for purposes of such subsection (a).''.

(2) CHIP.—Section 2102 of such Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

''(d) PROGRAM INTEGRITY.—A State child health plan shall include a description of the procedures to be used by the State—

''(1) to enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection through use of the appropriate procedures described in such subsection); and

''(2) to carry out any activities as required by the Secretary for purposes of such subsection.''.

(3) MEDICARE.—Section 1866(j) of such Act (42 U.S.C. 1395cc(j)) is amended by adding at the end the following new paragraph:

''(3) PROGRAM INTEGRITY.—The provisions of section 1128G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.''.

SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP PROGRAM DISCLOSURE REQUIREMENTS RELATING TO PREVIOUS AFFILIATIONS.

(a) IN GENERAL.—Section 1128G of the Social Security Act, as inserted by section 1631, is amended by adding at the end the following new subsection:

''(b) ENHANCED PROGRAM DISCLOSURE REQUIREMENTS.—

''(1) DISCLOSURE.—A provider of services or supplier who submits on or after July 1, 2011, an application for enrollment and renewing enrollment in a program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that has uncollected debt or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

''(2) ENHANCED SAFEGUARDS.—If the Secretary determines that such previous affiliation of such provider or supplier poses a risk of fraud, waste, or abuse, the Secretary may apply such enhanced safeguards as the Secretary determines necessary to reduce such risk associated with such provider or supplier enrolling or participating in the program under title XVIII, XIX, or XXI. Such safeguards may include enhanced oversight, such as enhanced screening of claims, required or unannounced (or required and unannounced) site visits or inspections, additional information reporting requirements, and conditioning such enrollment on the provision of a surety bond.

''(3) AUTHORITY TO DENY PARTICIPATION.—If the Secretary determines that there has been at least one such affiliation and that such affiliation or affiliations, as applicable, of such provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary may deny the application of such provider or supplier.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Paragraph (74) of section 1902(a) of such Act (42 U.S.C. 1396a(a)), as added by section 1631(b)(1), is amended—

(A) by inserting ''or subsection (b) of such section (relating to disclosure requirements)'' before '', and that the State''; and

(B) by inserting before the period the following: ''and apply any enhanced safeguards, with respect to a provider or supplier described in such subsection (b), as the Secretary determines necessary under such subsection (b)''.

(2) CHIP.—Subsection (d) of section 2102 of such Act (42 U.S.C. 1397bb), as added by section 1631(b)(2), is amended—

(A) in paragraph (1), by striking at the end ''and'';

(B) in paragraph (2) by striking the period at the end and inserting ''; and'' and

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

''(3) to enforce any determination made by the Secretary under subsection (b) of section 1128G (relating to disclosure requirements) and to apply any enhanced safeguards, with respect to a provider or supplier described in such subsection, as the Secretary determines necessary under such subsection.''.

SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 4101 of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under the fee schedule under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(ii)) that result in the ordering of additional services (such as lab tests), the prescription of drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.''.

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) IN GENERAL.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(1) in paragraph (3), by striking at the end ''and'';

(2) by redesignating paragraph (4) as paragraph (5); and

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

''(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and''.

(b) REFERENCE TO MEDICAID INTEGRITY PROGRAM.—For a similar provision with respect to the Medicaid Integrity Program, see section 1752.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Section 1866(j) of the Social Security Act (42 U.S.C. 42 U.S.C. 1395cc(j)), as amended by section 1631(d)(3), is further amended by adding at the end the following new paragraph:

''(4) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—The Secretary may not enroll (or renew the enrollment of) a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title if such provider of services or supplier fails to, subject to subparagraph (E), establish a compliance program that contains the core elements established under subparagraph (B) and certify in a manner determined by the Secretary, that the provider or suppler has established such a program.

''(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse for the organization's employees, and contractors; a confidential or anonymous mechanism, such as a hotline, to receive compliance questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.

''(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under subparagraph (B) and the date on which a provider of services and suppliers (other than physicians and skilled nursing facilities) shall be required to have established such a program for purposes of this subsection.

''(D) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of providers of services or suppliers (other than physicians and skilled nursing facilities) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse before implementing the requirements of this subsection to all providers of services and suppliers described in subparagraph (C).

''(E) TREATMENT OF SKILLED NURSING FACILITIES.—For the requirement for skilled nursing facilities to establish compliance and ethics programs see section 1819(d)(1)(C).

''(F) CONSTRUCTION.—Nothing in this subsection exempts a physician from participating in a compliance program established by a health care provider or other entity with which the physician is employed, under contract, or affiliated if such compliance is required by such provider or entity.''.

(b) REFERENCE TO SIMILAR MEDICAID PROVISION.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1753.

SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, C, and, D of title XVIII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not overburden providers and will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(2) PART B.—Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(3) PARTS C AND D.—Section 1857(d) of such Act is amended by adding at the end the following new paragraph:

''(7) PERIOD FOR SUBMISSION OF CLAIMS.—The contract shall require an MA organization or PDP sponsor to require any provider of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrollee of such organization, written request, signed by such enrollee, except in cases in which the Secretary finds it impracticable for the enrollee to do so, is filed for payment for such items and services in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the 1 calendar year period after such items and services are furnished. In applying the previous sentence, the Secretary may specify exceptions to the 1 calendar year period specified.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall be effective for items and services furnished on or after January 1, 2011.

SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL EQUIPMENT OR HOME HEALTH SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or other professional, as determined by the Secretary''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary,'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting '', or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary,'' after ''a physician''.

(c) DISCRETION TO EXPAND APPLICATION.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to other categories of items or services under this title, including covered part D drugs as defined in section 1860D–2(e), if the Secretary determines that such application would help to reduce the risk of waste, fraud, and abuse with respect to such other categories under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act is further amended by adding at the end the following new paragraph

''(9) The Secretary may disenroll, for a period of not more than one year for each act, a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc), is amended—

(1) in subparagraph (U), by striking at the end ''and'';

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

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

''(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 1639. FACE-TO-FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE ELIGIBILITY CERTIFICATIONS FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification or recertification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification or recertification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification or recertification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding before the period at the end the following: ''and shall require that any written order required for payment under this subsection be written only pursuant to the eligible health care professional authorized to make such written order documenting that such professional has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply a face-to-face encounter requirement similar to the requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such a decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID AND CHIP.—The face-to-face encounter requirements described in the amendments made by subsections (a) and (b) and any expanded application of similar requirements pursuant to subsection (c) shall apply with respect to a certification or recertification for home health services under title XIX or XXI of the Social Security Act, a written order for durable medical equipment under such title, and any other applicable item or service identified pursuant to subsection (c) for which payment is made under such title, respectively, in the same manner and to the same extent as such requirements apply in the case of such a certification or recertification, written order, or other applicable item or service so identified, respectively, under title XVIII of such Act.

SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AUTHORITY TO PROGRAM EXCLUSION INVESTIGATIONS.

(a) IN GENERAL.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a-7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to investigations beginning on or after January 1, 2010.

SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND MEDICAID OVERPAYMENTS.

Section 1128G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:

''(c) REPORTS ON AND REPAYMENT OF OVERPAYMENTS IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.—

''(1) REPORTING AND RETURNING OVERPAYMENTS.—If a person knows of an overpayment, the person must—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and

''(B) notify the Secretary, the State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) TIMING.—Subject to section 1620(d) of the Affordable Health Care for America Act, an overpayment must be reported and returned under paragraph (1)(A) by not later than the date that is 60 days after the date the person knows of the overpayment.

Any known overpayment retained later than the applicable date specified in this paragraph creates an obligation as defined in section 3729(b)(3) of title 31 of the United States Code.

''(3) CLARIFICATION.—Repayment of any overpayments (or refunding by withholding of future payments) by a provider of services or supplier does not otherwise limit the provider or supplier's potential liability for administrative obligations such as applicable interests, fines, and penalties or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud or other intentional conduct by the provider or supplier or the employees or agents of such provider or supplier.

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

''(A) KNOWS.—The term 'knows' has the meaning given the terms 'knowing' and 'knowingly' in section 3729(b) of title 31 of the United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII, XIX, or XXI to which the person, after applicable reconciliation (pursuant to the applicable existing process under the respective title), is not entitled under such title.

''(C) PERSON.—The term 'person' means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)), but excluding a beneficiary.''.

SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR OIG EXCLUSIONS TO BENEFICIARIES OF ANY FEDERAL HEALTH CARE PROGRAM.

Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL DIALYSIS FACILITIES.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(15) For purposes of evaluating or auditing payments made to renal dialysis facilities for items and services under this section under paragraph (1), each such renal dialysis facility, upon the request of the Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.''.

SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICARE.

(a) MEDICARE.—Section 1866(j)(1) of the Social Security Act (42 U.S.C. 1395cc(j)(1)) is amended by adding at the end the following new subparagraph:

''(D) BILLING AGENTS AND CLEARINGHOUSES REQUIRED TO BE REGISTERED UNDER MEDICARE.—Any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must be registered with the Secretary in a form and manner specified by the Secretary.''.

(b) MEDICAID.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1759.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after January 1, 2012.

SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.

Section 1128A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1))'';

(B) in paragraph (4)—

(i) in the matter preceding subparagraph (A), by striking ''participating in a program under title XVIII or a State health care program'' and inserting ''participating in a Federal health care program (as defined in section 1128B(f))''; and

(ii) in subparagraph (A), by striking ''title XVIII or a State health care program'' and

inserting ''a Federal health care program (as defined in section 1128B(f))'';

(C) by striking ''or'' at the end of paragraph (10);

(D) by inserting after paragraph (11) the following new paragraphs:

''(12) conspires to commit a violation of this section; or

''(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;''; and

(E) in the matter following paragraph (13), as inserted by subparagraph (D)—

(i) by striking ''or'' before ''in cases under paragraph (11)''; and

(ii) by inserting '', in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease'' after ''by an excluded individual''; and

(F) in the second sentence, by striking ''such false statement, omission, or misrepresentation)'' and inserting ''such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased)''.

(2) in subsection (c)(1), by striking ''six years'' and inserting ''10 years''; and

(3) in subsection (i)—

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

''(2) The term 'claim' means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 1128B(f)), whether or not the United States or a State agency has title to the money or property, that—

''(A) is presented or caused to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

''(B) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program's behalf or to advance a Federal health care program interest, and if the Federal health care program—

''(i) provides or has provided any portion of the money or property requested or demanded; or

''(ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.'';

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

''(3) The term 'item or service' means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program.'';

(C) in paragraph (6)—

(i) in subparagraph (C), by striking at the end ''or'';

(ii) in the first subparagraph (D), by striking at the end the period and inserting ''; or''; and

(iii) by redesignating the second subparagraph (D) as a subparagraph (E);

(D) by amending paragraph (7) to read as follows:

''(7) The terms 'knowing', 'knowingly', and 'should know' mean that a person, with respect to information—

''(A) has actual knowledge of the information;

''(B) acts in deliberate ignorance of the truth or falsity of the information; or

''(C) acts in reckless disregard of the truth or falsity of the information;

and require no proof of specific intent to defraud.''; and

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

''(8) The term 'obligation' means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

''(9) The term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.''.

SEC. 1646. REQUIRING PROVIDER AND SUPPLIER PAYMENTS UNDER MEDICARE TO BE MADE THROUGH DIRECT DEPOSIT OR ELECTRONIC FUNDS TRANSFER (EFT) AT INSURED DEPOSITORY INSTITUTIONS.

(a) MEDICARE.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(e) LIMITATION ON PAYMENT TO PROVIDERS OF SERVICES AND SUPPLIERS.—No payment shall be made under this title for items and services furnished by a provider of services or supplier unless each payment to the provider of services or supplier is in the form of direct deposit or electronic funds transfer to the provider of services' or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to each payment made to a provider of services, provider, or supplier on or after such date (not later than July 1, 2012) as the Secretary of Health and Human Services shall specify, regardless of when the items and services for which such payment is made were furnished.

SEC. 1647. INSPECTOR GENERAL FOR THE HEALTH CHOICES ADMINISTRATION.

(a) ESTABLISHMENT; APPOINTMENT.—There is hereby established an Office of Inspector General for the Health Choices Administration, to be headed by the Inspector General for the Health Choices Administration to be appointed by the President, by and with the advice and consent of the Senate.

(b) AMENDMENTS TO THE INSPECTOR GENERAL ACT OF 1978.—

(1) APPLICATION TO HEALTH CHOICES ADMINISTRATION.—Section 12 of the Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(A) in paragraph (1), by striking ''or the Federal Cochairpersons of the Commissions established under section 15301 of title 40, United States Code'' and inserting ''the Federal Cochairpersons of the Commissions established under section 15301 of title 40, United States Code; or the Commissioner of the Health Choices Administration established under section 241 of the Affordable Health Care for America Act''; and

(B) in paragraph (2), by striking ''or the Commissions established under section 15301 of title 40, United States Code'' and inserting ''the Commissions established under section 15301 of title 40, United States Code, or the Health Choices Administration established under section 241 of the Affordable Health Care for America Act''.

(2) SPECIAL PROVISIONS RELATING TO HEALTH CHOICES ADMINISTRATION AND HHS.—The Inspector General Act of 1978 (5 U.S.C. App.) is further amended by inserting after section 8L the following new section:

''SEC. 8M SPECIAL PROVISIONS RELATING TO THE HEALTH CHOICES ADMINISTRATION AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

''(a) The Inspector General of the Health Choices Administration shall—

''(1) have the authority to conduct, supervise, and coordinate audits, evaluations, and investigations of the programs and operations of the Health Choices Administration established under section 241 of the Affordable Health Care for America Act, including matters relating to fraud, abuse, and misconduct in connection with the admission and continued participation of any health benefits plan participating in the Health Insurance Exchange established under section 301 of such Act;

''(2) have the authority to conduct audits, evaluations, and investigations relating to any private Exchange-participating health benefits plan, as defined in section 201(c) of such Act;

''(3) have the authority, in consultation with the Office of Inspector General for the Department of Health and Human Services and subject to subsection (b), to conduct audits, evaluations, and investigations relating to the public health insurance option established under section 321 of such Act; and

''(4) have access to all relevant records necessary to carry out this section, including records relating to claims paid by Exchange-participating health benefits plans.

''(b) Authority granted to the Health Choices Administration and the Inspector General of the Health Choices Administration by the Affordable Health Care for America Act does not limit the duties, authorities, and responsibilities of the Office of Inspector General for the Department of Health and Human Services, as in existence as of the date of the enactment of the Affordable Health Care for America Act, to oversee programs and operations of such department. The Office of Inspector General for the Department of Health and Human Services retains primary jurisdiction over fraud and abuse in connection with payments made under the public health insurance option established under section 321 of such Act and administered by the Department of Health and Human Services.''.

(3) APPLICATION OF RULE OF CONSTRUCTION.—Section 8J of the Inspector General Act of 1978 (5 U.S.C. App.) is amended by striking ''or 8H'' and inserting '', 8H, or 8M''.

(c) EFFECTIVE DATE.—The provisions of and amendments made by this section shall take effect on the date of the enactment of this Act.

Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

(a) GAO ACCESS.—Subchapter II of chapter 7 of title 31, United States Code, is amended by adding at the end the following:

''§ 721. Access to certain information

''No provision of the Social Security Act shall be construed to limit, amend, or supersede the authority of the Comptroller General to obtain any information, to inspect any record, or to interview any officer or employee under section 716 of this title, including with respect to any information disclosed to or obtained by the Secretary of Health and Human Services under part C or D of title XVIII of the Social Security Act.''.

(b) ACCESS TO MEDICARE PART D DATA PROGRAM INTEGRITY PURPOSES.—

(1) PROVISION OF INFORMATION AS CONDITION OF PAYMENT.—Section 1860D–15(d)(2)(B) of the Social Security Act (42 U.S.C. 1395w–115(d)(2)(B)) is amended—

(A) by striking ''may be used by officers'' and all that follows through the period and inserting ''may be used by—''; and

(B) by adding at the end the following clauses:

''(i) officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section; and

''(ii) the Inspector General of the Department of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and the Attorney General only for the purposes of protecting the integrity of the programs under this title and title XIX; conducting the activities described in section 1893 and subparagraphs (A) through (E) of section 1128C(a)(1); and for investigation, audit, evaluation, oversight, and law enforcement purposes to the extent consistent with applicable law.''.

(2) GENERAL DISCLOSURE OF INFORMATION.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–115(f)(2)) is amended—

(A) by striking ''may be used by officers'' and all that follows through the period and inserting ''may be used by—''; and

(B) by adding at the end the following subparagraphs:

''(A) officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section; and

''(B) the Inspector General of the Department of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and the Attorney General only for the purposes of protecting the integrity of the programs under this title and title XIX; conducting the activities described in section 1893 and subparagraphs (A) through (E) of section 1128C(a)(1); and for investigation, audit, evaluation, oversight, and law enforcement purposes to the extent consistent with applicable law.''.

SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) IN GENERAL.—To eliminate duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) established under section 1128E of the Social Security Act and the National Practitioner Data Bank (NPBD) established under the Health Care Quality Improvement Act of 1986, section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) in subsection (a), by striking ''Not later than'' and inserting ''Subject to subsection (h), not later than'';

(2) in the first sentence of subsection (d)(2), by striking ''(other than with respect to requests by Federal agencies)''; and

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

''(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK; TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Secretary shall implement a process to eliminate duplication between the Healthcare Integrity and Protection Data Bank (in this subsection referred to as the 'HIPDB' established pursuant to subsection (a) and the National Practitioner Data Bank (in this subsection referred to as the 'NPDB') as implemented under the Health Care Quality Improvement Act of 1986 and section 1921 of this Act, including systems testing necessary to ensure that information formerly collected in the HIPDB will be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Except as otherwise provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report), access to, and other treatment of the information specified in this section.''.

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HHS OFFICE OF THE INSPECTOR GENERAL.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding at the end ''and'';

(2) in subparagraph (D), by striking at the end '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the one year period that begins on the effective date specified in subsection (e)(1), the information described in paragraph (2) shall be available from the National Practitioner Data Bank (described in section 1921 of the Social Security Act) to the Secretary of Veterans Affairs without charge.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(d) FUNDING.—Notwithstanding any provisions of this Act, sections 1128E(d)(2) and 1817(k)(3) of the Social Security Act, or any other provision of law, there shall be available for carrying out the transition process under section 1128E(h) of the Social Security Act over the period required to complete such process, and for operation of the National Practitioner Data Bank until such process is completed, without fiscal year limitation—

(1) any fees collected pursuant to section 1128E(d)(2) of such Act; and

(2) such additional amounts as necessary, from appropriations available to the Secretary and to the Office of the Inspector General of the Department of Health and Human Services under clauses (i) and (ii), respectively, of section 1817(k)(3)(A) of such Act, for costs of such activities during the first 12 months following the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made—

(1) by subsection (a)(2) shall take effect on the first day after the Secretary of Health and Human Services certifies that the process implemented pursuant to section 1128E(h) of the Social Security Act (as added by subsection (a)(3)) is complete; and

(2) by subsection (b) shall take effect on the earlier of the date specified in paragraph (1) or the first day of the second succeeding fiscal year after the fiscal year during which this Act is enacted.

SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS.

The provisions of sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (and standards promulgated pursuant to such sections) and the Privacy Act of 1974 shall apply with respect to the provisions of this subtitle and amendments made by this subtitle.

SEC. 1654. DISCLOSURE OF MEDICARE FRAUD AND ABUSE HOTLINE NUMBER ON EXPLANATION OF BENEFITS.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(d) Any statement or notice containing an explanation of the benefits available under this title, including the notice required by subsection (a), distributed for periods after July 1, 2011, shall prominently display in a manner prescribed by the Secretary a separate toll-free telephone number maintained by the Secretary for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.''.

(b) CONFORMING AMENDMENTS.—Section 1804(c) of the Social Security Act (42 U.S.C. 1395b–2(c)) is amended—

(1) in paragraph (2), by adding ''and'' at the end;

(2) in paragraph (3), by striking ''; and'' and inserting a period; and

(3) by striking paragraph (4).

TITLE VII—MEDICAID AND CHIP

Subtitle A—Medicaid and Health Reform

SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by adding at the end the following new subclause:

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary in consultation with the Health Choices Commissioner) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning

with 2015) with respect to amounts described in subsection (y)''; and

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

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by sections 1714(a)(4) and 1731(c), is further amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiv);

(ii) by adding ''or'' at the end of clause (xv); and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

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

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (l)(1)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(XI) beginning with 2014, who are under 19 years of age, who are not described in subclause (X), and who would be eligible for child health assistance under a State child health plan insofar as such plan provides benefits under this title (as described in section 2101(a)(2)) based on such plan as in effect as of June 16, 2009; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), 1902(a)(10)(A)(i)(XI), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX), (X), or (XI) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X), 1902(a)(10)(A)(i)(XI),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) INCREASED MATCHING RATE FOR TEMPORARY COVERAGE OF CERTAIN NEWBORNS.—Section 1905(y) of such Act, as added by subsection (a)(3)(B), is amended by adding at the end the following:

''(2) Amounts expended for medical assistance for children described in section 305(d)(1) of the Affordable Health Care for America Act during the time period specified in such section.''.

(d) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by adding at the end the following new section:

'' REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS

''SEC. 1943. (a) COORDINATION WITH NHI EXCHANGE THROUGH MEMORANDUM OF UNDERSTANDING.—

''(1) IN GENERAL.—The State shall enter into a Medicaid memorandum of understanding described in section 305(e)(2) of the Affordable Health Care for America Act with the Health Choices Commissioner, acting in consultation with the Secretary, with respect to coordinating the implementation of the provisions of division A of such Act with the State plan under this title in order to ensure the enrollment of Medicaid eligible individuals in acceptable coverage. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State plan under this title.

''(2) ENROLLMENT OF EXCHANGE-REFERRED INDIVIDUALS.—

''(A) NON-TRADITIONAL INDIVIDUALS.—Pursuant to such memorandum the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a non-traditional Medicaid eligible individual. The State shall not do any redeterminations of eligibility for such individuals unless the periodicity of such redeterminations is consistent with the periodicity for redeterminations by the Commissioner of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, as specified under such memorandum.

''(B) TRADITIONAL INDIVIDUALS.—Pursuant to such memorandum, the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

''(3) DETERMINATIONS OF ELIGIBILITY FOR AFFORDABILITY CREDITS.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, under such memorandum—

''(A) the State Medicaid agency shall conduct such determinations for any Exchange-eligible individual who requests such a determination;

''(B) in the case that a State Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency shall forward the information on the basis of which such determination was made to the Commissioner; and

''(C) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

''(4) REFERRALS UNDER MEMORANDUM.—Pursuant to such memorandum, if an individual applies to the State for assistance in obtaining health coverage and the State determines that the individual is not eligible for medical assistance under this title and is not authorized under such memorandum to make an determination with respect to eligibility for coverage and affordability credits through the Health Insurance Exchange, the State shall refer the individual to the Commissioner for a determination of such eligibility and, with the individual's authorization, provide to the Commissioner information obtained by the State as part of the application process.

''(5) ADDITIONAL TERMS.—Such memorandum shall include such additional provisions as are necessary to implement efficiently the provisions of this section and title II of division A of the Affordable Health Care for America Act.

''(b) TREATMENT OF CERTAIN NEWBORNS.—

''(1) IN GENERAL.—In the case of a child who is deemed under section 305(d) of the Affordable Health Care for America Act to be a Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in paragraph (2) of such section, of the child's eligibility for medical assistance under this title.

''(2) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In accordance with paragraph (2) of section 305(d) of the Affordable Health Care for America Act, in the case of a child described in paragraph (1) of such section who at the end of the period referred to in such paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as

the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its plan under this title pursuant to paragraph (1)) to be a Medicaid eligible individual described in section 1902(l)(1)(B).

''(c) DEFINITIONS.—In this section:

''(1) MEDICAID ELIGIBLE INDIVIDUAL.—The term 'Medicaid eligible individual' means an individual who is eligible for medical assistance under Medicaid.

''(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term 'traditional Medicaid eligible individual' means a Medicaid eligible individual other than an individual who is—

''(A) a Medicaid eligible individual by reason of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

''(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

''(3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term 'non-traditional Medicaid eligible individual' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

''(4) MEMORANDUM.—The term 'memorandum' means a Medicaid memorandum of understanding under section 305(e)(2) of the Affordable Health Care for America Act.

''(5) Y1.—The term 'Y1' has the meaning given such term in section 100(c) of the Affordable Health Care for America Act.''.

(b) CONFORMING AMENDMENTS TO ERROR RATE.—

(1) Section 1903(u)(1)(D) of the Social Security Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following new clause:

''(vi) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made that are attributable to an error in an eligibility determination under subtitle C of title II of division A of the Affordable Health Care for America Act.''.

(2) Section 2105(c)(11) of such Act (42 U.S.C. 1397ee(c)(11)) is amended by adding at the end the following new sentence: ''Clause (vi) of section 1903(u)(1)(D) shall apply with respect to the application of such requirements under this title and title XIX.''.

SEC. 1703. CHIP AND MEDICAID MAINTENANCE OF ELIGIBILITY.

(a) CHIP MAINTENANCE OF ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a), as amended by section 1631(b)(1)(D)—

(A) by striking ''and'' at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide for maintenance of effort under the State child health plan under title XXI in accordance with subsection (gg).''; and

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

''(gg) CHIP MAINTENANCE OF ELIGIBILITY REQUIREMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), as a condition of its State plan under this title under subsection (a)(75) and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after the date of the enactment of this subsection and before CHIP MOE termination date specified in paragraph (3), a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan under title XXI (including any waiver under such title or demonstration project under section 1115) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009.

''(2) LIMITATION.—Paragraph (1) shall not be construed as preventing a State from imposing a limitation described in section 2110(b)(5)(C)(i)(II) for a fiscal year in order to limit expenditures under its State child health plan under title XXI to those for which Federal financial participation is available under section 2105 for the fiscal year.

''(3) CHIP MOE TERMINATION DATE.—In paragraph (1), the 'CHIP MOE termination date' for a State is the date that is the last day of Y1 (as defined in section 100(c) of the Affordable Health Care for America Act).

''(4) CHIP TRANSITION REPORT.—Not later than December 31, 2011, the Secretary shall submit to Congress a report—

''(A) that compares the benefits packages offered under an average State child health plan under title XXI in 2011 and to the benefit standards initially adopted under section 224(b) of the Affordable Health Care for America Act and for affordability credits under subtitle C of title II of division C of such Act; and

''(B) that includes such recommendations as may be necessary to ensure that—

''(i) such coverage is at least comparable to the coverage provided to children under such an average State child health plan; and

''(ii) there are procedures in effect for the enrollment of CHIP enrollees (including CHIP-eligible pregnant women) at the end of Y1 under this title, into a qualified health benefits plan offered through the Health Insurance Exchange, or into other acceptable coverage (as defined for purposes of such Act) without interruption of coverage or a written plan of treatment.''.

(b) MEDICAID MAINTENANCE OF EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN EXCHANGE AND MEDICAID.—

(1) IN GENERAL.—Section 1903 of such Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) MAINTENANCE OF MEDICAID EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN HEALTH INSURANCE EXCHANGE AND MEDICAID.—

''(1) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), a State is not eligible for payment under subsection (a) for a calendar quarter beginning after the date of the enactment of this subsection if eligibility standards, methodologies, or procedures under its plan under this title (including any waiver under this title or demonstration project under section 1115) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009. The Secretary shall extend such a waiver (including the availability of Federal financial participation under such waiver) for such period as may be required for a State to meet the requirement of the previous sentence.

''(B) EXCEPTION FOR CERTAIN DEMONSTRATION PROJECTS.—In the case of a State demonstration project under section 1115 in effect on June 16, 2009, that permits individuals to be eligible solely to receive a premium or cost-sharing subsidy for individual or group health insurance coverage, effective for coverage provided in Y1—

''(i) the Secretary shall permit the State to amend such waiver to apply more restrictive eligibility standards, methodologies, or procedures with respect to such individuals under such waiver; and

''(ii) the application of such more restrictive, standards, methodologies, or procedures under such an amendment shall not be considered in violation of the requirement of subparagraph (A).

''(2) REMOVAL OF ASSET TEST FOR CERTAIN ELIGIBILITY CATEGORIES.—

''(A) IN GENERAL.—A State is not eligible for payment under subsection (a) for a calendar quarter beginning on or after the first day of Y1 (as defined in section 100(c) of the Affordable Health Care for America Act), if the State applies any asset or resource test in determining (or redetermining) eligibility of any individual on or after such first day under any of the following:

''(i) Subclause (I), (III), (IV), (VI), (VIII), (IX), (X), or (XI) of section 1902(a)(10)(A)(i).

''(ii) Subclause (II), (IX), (XIV) or (XVII) of section 1902(a)(10)(A)(ii).

''(iii) Section 1931(b).

''(B) OVERRIDING CONTRARY PROVISIONS; REFERENCES.—The provisions of this title that prevent the waiver of an asset or resource test described in subparagraph (A) are hereby waived.

''(C) REFERENCES.—Any reference to a provision described in a provision in subparagraph (A) shall be deemed to be a reference to such provision as modified through the application of subparagraphs (A) and (B).''.

(2) CONFORMING AMENDMENTS.—(A) Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in the matter before clause (i), by inserting ''subject to section 1903(aa)(2),'' after ''(A)''.

(B) Section 1931(b)(1) of such Act (42 U.S.C. 1396u–1(b)(1)) is amended by inserting ''and section 1903(aa)(2)'' after ''and (3)''.

(c) STANDARDS FOR BENCHMARK PACKAGES.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in each of paragraphs (1) and (2), by inserting ''subject to paragraph (5),'' after ''subsection (a)(1),''; and

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

''(5) MINIMUM STANDARDS.—Effective January 1, 2013, any benchmark benefit package (or benchmark equivalent coverage under paragraph (2)) must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange.''.

(d) REPEAL OF CHIP.—Section 2104(a) of the Social Security Act is amended by inserting at the end the following:

''No funds shall be appropriated or authorized to be appropriated under this section for fiscal year 2014 and subsequent years.''.

SEC. 1704. REDUCTION IN MEDICAID DSH.

(a) REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing the report, the Secretary shall consult with community-based health care networks serving low-income beneficiaries.

(2) MATTERS TO BE INCLUDED.—The report shall include the following:

(A) RECOMMENDATIONS.—Recommendations regarding—

(i) the appropriate targeting of Medicaid DSH within States; and

(ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to a State to the number of uninsured individuals in such State.

(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in paragraph (2) of subsection (b) for purposes of implementing the requirements of such subsection.

(3) COORDINATION WITH MEDICARE DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicare DSH under section 1112.

(4) MEDICAID DSH.—In this section, the term ''Medicaid DSH'' means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(1) REDUCTIONS.—

(A) IN GENERAL.—For each of fiscal years 2017 through 2019 the Secretary shall effect the following reductions:

(i) REDUCTION DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under paragraph (2) for the State for the fiscal year.

(ii) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for each calendar quarter in the fiscal year, in the manner specified in subparagraph (C), in an amount equal to ¼ of the DSH allotment reduction under clause (i) for the State for the fiscal year.

(B) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under subparagraph (A)(i) shall be equal to—

(i) $1,500,000,000 for fiscal year 2017;

(ii) $2,500,000,000 for fiscal year 2018; and

(iii) $6,000,000,000 for fiscal year 2019.

The Secretary shall distribute such aggregate reduction among States in accordance with paragraph (2).

(C) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under subparagraph (A)(ii) for a State for a quarter shall be deemed an overpayment to the State under title XIX of the Social Security Act to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2) of such Act (42 U.S.C. 1396b(d)(2)). Such a disallowance is not subject to a reconsideration under 1116(d) of such Act (42 U.S.C. 1316(d)).

(D) DEFINITIONS.—In this section:

(i) STATE.—The term ''State'' means the 50 States and the District of Columbia.

(ii) DSH ALLOTMENT.—The term ''DSH allotment'' means, with respect to a State for a fiscal year, the allotment made under section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) to the State for the fiscal year.

(2) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out paragraph (1) through use of a DSH Health Reform methodology issued by the Secretary that imposes the largest percentage reductions on the States that—

(A) have the lowest percentages of uninsured individuals (determined on the basis of audited hospital cost reports) during the most recent year for which such data are available; or

(B) do not target their DSH payments on—

(i) hospitals with high volumes of Medicaid inpatients (as defined in section 1923(b)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(b)(1)(A)); and

(ii) hospitals that have high levels of uncompensated care (excluding bad debt).

(3) DSH ALLOTMENT PUBLICATIONS.—

(A) IN GENERAL.—Not later than the publication deadline specified in subparagraph (B), the Secretary shall publish in the Federal Register a notice specifying the DSH allotment to each State under 1923(f) of the Social Security Act for the respective fiscal year specified in such subparagraph, consistent with the application of the DSH Health Reform methodology described in paragraph (2).

(B) PUBLICATION DEADLINE.—The publication deadline specified in this subparagraph is—

(i) January 1, 2016, with respect to DSH allotments described in subparagraph (A) for fiscal year 2017;

(ii) January 1, 2017, with respect to DSH allotments described in subparagraph (A) for fiscal year 2018; and

(iii) January 1, 2018, with respect to DSH allotments described in subparagraph (A) for fiscal year 2019.

(c) CONFORMING AMENDMENTS.—

(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

''(7) SPECIAL RULE FOR FISCAL YEARS 2017, 2018, AND 2019.—For each of fiscal years 2017, 2018, and 2018, the DSH allotments under this subsection are subject to reduction under section 1704(b) of the Affordable Health Care for America Act.''.

(2) The second sentence of section 1923(b)(4) of such Act (42 U.S.C. 1396r–4(b)(4)) is amended by inserting before the period the following: ''or to affect the authority of the Secretary to issue and implement the DSH Health Reform methodology under section 1704(b)(2) of the Affordable Health Care for America Act''.

(d) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DISCRIMINATION.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new paragraph:

''(4) No hospital may be defined or deemed as a disproportionate share hospital, or as an essential access hospital (for purposes of subsection (f)(6)(A)(iv)), under a State plan under this title or subsection (b) of this section (including any demonstration project under section 1115) unless the hospital—

''(A) provides services to beneficiaries under this title without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary under this title, or any other ground unrelated to such beneficiary's need for the services or the availability of the needed services in the hospital; and

''(B) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to expenditures made on or after July 1, 2010.

SEC. 1705. EXPANDED OUTSTATIONING.

(a) IN GENERAL.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by striking ''under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''(including receipt and processing of applications of individuals for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act pursuant to a Medicaid memorandum of understanding under section 1943(a)(1))''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendment made by subsection (a) shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

Subtitle B—Prevention

SEC. 1711. REQUIRED COVERAGE OF PREVENTIVE SERVICES.

(a) COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1701(a)(3)(B), is amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following: ''; and (D) preventive services described in subsection (z)''; and

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

''(z) PREVENTIVE SERVICES.—The preventive services described in this subsection are services not otherwise described in subsection (a) or (r) that the Secretary determines are—

''(1)(A) recommended with a grade of A or B by the Task Force for Clinical Preventive Services; or

''(B) vaccines recommended for use as appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) appropriate for individuals entitled to medical assistance under this title.''.

(b) ELIMINATION OF COST-SHARING.—

(1) Subsections (a)(2)(D) and (b)(2)(D) of section 1916 of such Act (42 U.S.C. 1396o) are each amended by inserting ''preventive services described in section 1905(z),'' after ''emergency services (as defined by the Secretary),''.

(2) Section 1916A(a)(1) of such Act (42 U.S.C. 1396o–1 (a)(1)) is amended by inserting '', preventive services described in section 1905(z),'' after ''subsection (c)''.

(c) CONFORMING AMENDMENT.—Section 1928 of such Act (42 U.S.C. 1396s) is amended—

(1) in subsection (c)(2)(B)(i), by striking ''the advisory committee referred to in subsection (e)'' and inserting ''the Director of the Centers for Disease Control and Prevention'';

(2) in subsection (e), by striking ''Advisory Committee'' and all that follows and inserting ''Director of the Centers for Disease Control and Prevention.''; and

(3) by striking subsection (g).

(d) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1712. TOBACCO CESSATION.

(a) DROPPING TOBACCO CESSATION EXCLUSION FROM COVERED OUTPATIENT DRUGS.—Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) in subparagraph (G), by inserting before the period at the end the following: '', except agents approved by the Food and Drug Administration for purposes of promoting, and when used to promote, tobacco cessation''; and

(3) by redesignating subparagraphs (F) through (K) as subparagraphs (E) through (J), respectively.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs and services furnished on or after January 1, 2010.

SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1701(a)(3)(B) and 1711(a), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) nurse home visitation services (as defined in subsection (aa)); and''; and

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

''(aa) The term 'nurse home visitation services' means home visits by trained

nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary based upon evidence, that such services are effective in one or more of the following:

''(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

''(2) Reducing the incidence of child abuse, neglect, and injury, improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

''(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide nurse home visitation services as part of another class of items and services falling within the definition of medical assistance or child health assistance under the respective title, or as an administrative expenditure for which payment is made under section 1903(a) or 2105(a) of such Act, respectively, on or after the date of the enactment of this Act.

SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XX) who are described in subsection (hh) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1703, is amended by adding at the end the following new subsection:

''(hh)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of subsection (a)(10) pursuant to a demonstration project waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting '', and (XV) the medical assistance made available to an individual described in subsection (hh) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by section 1731(c), is amended in the matter preceding paragraph (1)—

(A) in clause (xiii), by striking ''or'' at the end;

(B) in clause (xiv), by adding ''or'' at the end; and

(C) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(hh),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(hh) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(hh), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(hh); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting ''for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 1703(c)(2), is amended by adding at the end the following:

''(6) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

Subtitle C—Access

SEC. 1721. PAYMENTS TO PRIMARY CARE PRACTITIONERS.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b) as amended by sections 1703(a), 1714(a), 1731(a), and 1746, is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for primary care services (as defined in subsection (kk)(1)) furnished by physicians (or for services furnished by other health care professionals that would be primary care services under such section if furnished by a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (kk)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, or 100 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2012 and each subsequent year;''; and

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

''(kk) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13)(C):

''(1) PRIMARY CARE SERVICES DEFINED.—The term 'primary care services' means evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary).

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASE IN PAYMENT USING INCREASED FMAP.—Section 1905(y) of the Social Security Act, as added by section 1701(a)(3)(B) and as amended by section 1701(c)(2), is amended by adding at the end the following:

''(3)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of June 16, 2009.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 1722. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section a medical home pilot program under which a State may apply to the Secretary for approval of a medical home pilot project described in subsection (b) (in this section referred to as a ''pilot project'') for the application of the medical home concept under title XIX of the Social Security Act. The pilot program shall operate for a period of up to 5 years.

(b) PILOT PROJECT DESCRIBED.—

(1) IN GENERAL.—A pilot project is a project that applies one or more of the medical home models described in section 1866F(a)(3) of the Social Security Act (as inserted by section 1302(a)) or such other model as the Secretary may approve, to individuals (including medically fragile children and high-risk pregnant women) who are eligible for medical assistance under title XIX of the Social Security Act. The Secretary shall provide for appropriate coordination of the pilot program under this section with the medical home pilot program under section 1866F of such Act.

(2) LIMITATION.—A pilot project shall be for a duration of not more than 5 years.

(3) CONSIDERATION FOR CERTAIN TECHNOLOGIES.—In considering applications for pilots projects under this section, the Secretary may approve a project which tests the effectiveness of applications and devices, such as wireless patient management technologies, that are approved by the Food and Drug Administration and enable providers and practitioners to communicate directly with their patients in managing chronic illness.

(c) ADDITIONAL INCENTIVES.—In the case of a pilot project, the Secretary may—

(1) waive the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) and section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase to up to 90 percent (for the first 2 years of the pilot program) or 75 percent (for the next 3 years) the matching percentage for administrative expenditures (such as those for community care workers).

(d) MEDICALLY FRAGILE CHILDREN.—In the case of a model involving medically fragile children, the model shall ensure that the patient-centered medical home services received by each child, in addition to fulfilling the requirements under 1866F(b)(1) of the Social Security Act, provide for continuous involvement and education of the parent or caregiver and for assistance to the child in obtaining necessary transitional care if a child's enrollment ceases for any reason.

(e) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the criteria described in section 1866F(e)(1) of the Social Security Act (as inserted by section 1123), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

(f) FUNDING.—The additional Federal financial participation resulting from the implementation of the pilot program under this section may not exceed in the aggregate $1,235,000,000 over the 5-year period of the program.

SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.

(a) IN GENERAL.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)), as added by section 201(b)(2)(A) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting ''and other individuals'' after ''children of families''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment for translation or interpretation services furnished on or after January 1, 2010.

SEC. 1724. OPTIONAL COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1713(a), is amended—

(1) in subsection (a)—

(A) by redesignating paragraph (29) as paragraph (30);

(B) in paragraph (28), by striking at the end ''and''; and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)), including by a licensed birth attendant (as defined in subparagraph (C)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital; and

''(ii) where childbirth is planned to occur away from the pregnant woman's residence.

''(C) The term 'licensed birth attendant' means an individual who is licensed or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a licensed birth attendant.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER THE VACCINES FOR CHILDREN PROGRAM.

Section 1928(b)(2)(A)(iii)(I) of the Social Security Act (42 U.S.C. 1396s(b)(2)(A)(iii)(I)) is amended—

(1) by striking ''or a rural health clinic'' and inserting '', a rural health clinic''; and

(2) by inserting ''or a public health clinic,'' after ''1905(l)(1)),''.

SEC. 1726. REQUIRING COVERAGE OF SERVICES OF PODIATRISTS.

(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

SEC. 1726A. REQUIRING COVERAGE OF SERVICES OF OPTOMETRISTS.

(a) IN GENERAL.—Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396d(a)(5)) is amended—

(1) by striking ''and'' before ''(B)''; and

(2) by inserting before the semicolon at the end the following: '', and (C) medical and other health services (as defined in section 1861(s)) as authorized by State law, furnished by an optometrist (described in section 1861(r)(4)) to the extent such services may be performed under State law''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by subsection (a) shall take effect 90 days after the

date of the enactment of this Act and shall apply to services furnished or other actions required on or after such date.

SEC. 1727. THERAPEUTIC FOSTER CARE.

(a) RULE OF CONSTRUCTION.—Nothing in this title shall prevent or limit a State from covering therapeutic foster care for eligible children in out-of-home placements under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(b) THERAPEUTIC FOSTER CARE DEFINED.—For purposes of this section, the term ''therapeutic foster care'' means a foster care program that provides—

(1) to the child—

(A) structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communications, and behavioral skills;

(B) crisis intervention and crisis support services;

(C) medication monitoring;

(D) counseling; and

(E) case management services; and

(2) specialized training for the foster parent and consultation with the foster parent on the management of children with mental illnesses and related health and developmental conditions.

SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1925 the following new section:

''ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

''SEC. 1926. (a) IN GENERAL.—A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year (beginning with 2011) unless, by not later than April 1 before the beginning of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in such year and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to medicaid managed care organizations under sections 1903(m) and 1932 take into account such payment rates.

''(b) SECRETARIAL REVIEW.—The Secretary, by not later than 90 days after the date of submission of a plan amendment under subsection (a), shall—

''(1) review each such amendment for compliance with the requirement of section 1902(a)(30)(A); and

''(2) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment that meets such requirement.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 1729. PRESERVING MEDICAID COVERAGE FOR YOUTHS UPON RELEASE FROM PUBLIC INSTITUTIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a), as amended by section 1631(b) and 1703(a), is amended—

(1) by striking ''and'' at the end of paragraph (74);

(2) by striking the period at the end of paragraph (75) and inserting ''; and''; and

(3) by inserting after paragraph (75) the following new paragraph:

''(76) provide that in the case of any youth who is 18 years of age or younger, was enrolled for medical assistance under the State plan immediately before becoming an inmate of a public institution, is 18 years of age or younger upon release from such institution, and is eligible for such medical assistance under the State plan at the time of release from such institution—

''(A) during the period such youth is incarcerated in a public institution, the State shall not terminate eligibility for medical assistance under the State plan for such youth;

''(B) during the period such youth is incarcerated in a public institution, the State shall establish a process that ensures—

''(i) that the State does not claim federal financial participation for services that are provided to such youth and that are excluded under subsection 1905(a)(28)(A); and

''(ii) that the youth receives medical assistance for which federal participation is available under this title;

''(C) on or before the date such youth is released from such institution, the State shall ensure that such youth is enrolled for medical assistance under this title, unless and until there is a determination that the individual is no longer eligible to be so enrolled; and

''(D) the State shall ensure that enrollment under subparagraph (C) will be completed before such date so that the youth can access medical assistance under this title immediately upon leaving the institution.''

SEC. 1730. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139A the following new section:

''SEC. 1139B. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

''(a) MATERNITY CARE QUALITY MEASURES UNDER MEDICAID AND CHIP.—

''(1) DEVELOPMENT OF MEASURES.—No later than January 1, 2011, the Secretary shall develop and publish for comment a proposed set of measures that accurately describe the quality of maternity care provided under State plans under titles XIX and XXI. The Secretary shall publish a final recommended set of such measures no later than July 1, 2011.

''(2) STANDARDIZED REPORTING FORMAT.—No later than January 1, 2012, the Secretary shall develop and publish a standardized reporting format for maternity care quality measures for use by State programs under titles XIX and XXI to collect data from managed care entities and providers and practitioners that participate in such programs and to report maternity care quality measures to the Secretary.

''(b) OTHER ADULT HEALTH QUALITY MEASURES UNDER MEDICAID.—

''(1) DEVELOPMENT OF MEASURES.—The Secretary shall develop quality measures that are not otherwise developed under section 1192 for services received under State plans under title XIX by individuals who are 21 years of age or older but have not attained age 65. The Secretary shall publish such quality measures through notice and comment rulemaking.

''(2) STANDARDIZED REPORTING FORMAT.—The Secretary shall develop and publish a standardized reporting format for quality measures developed under paragraph (1) and section 1192 for services furnished under State plans under title XIX to individuals who are 21 years of age or older but have not attained age 65 for use under such plans and State plans under title XXI. The format shall enable State agencies administering such plans to collect data from managed care entities and providers and practitioners that participate in such plans and to report quality measures to the Secretary.

''(c) DEVELOPMENT PROCESS.—With respect to the development of quality measures under subsections (a) and (b)—

''(1) USE OF QUALIFIED ENTITIES.—The Secretary may enter into agreements with public, nonprofit, or academic institutions with technical expertise in the area of health quality measurement to assist in such development. The Secretary may carry out these agreements by contract, grant, or otherwise.

''(2) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT.—The Secretary shall obtain the input of stakeholders with respect to such quality measures using a process similar to that described in section 1808(d).

''(3) COORDINATION.—The Secretary shall coordinate the development of such measures under such subsections and with the development of child health quality measures under section 1139A.

''(d) ANNUAL REPORT TO CONGRESS.—No later than January 1, 2013, and annually thereafter, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives the Committee on Finance of the Senate regarding—

''(1) the availability of reliable data relating to the quality of maternity care furnished under State plans under titles XIX and XXI;

''(2) the availability of reliable data relating to the quality of services furnished under State plans under title XIX to adults who are 21 years of age or older but have not attained age 65; and

''(3) recommendations for improving the quality of such care and services furnished under such State plans.

''(e) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual who receives medical assistance under title XIX or child health assistance under title XXI.

''(f) APPROPRIATION.—For purposes of carrying out this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated $40,000,000 for the 5-fiscal-year period beginning with fiscal year 2010. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section an accountable care program under which a State may apply to the Secretary for approval of an accountable care organization pilot program described in subsection (b) (in this section referred to as a ''pilot program'') for the application of the accountable care organization concept under title XIX of the Social Security Act.

(b) PILOT PROGRAM DESCRIBED.—

(1) IN GENERAL.—The pilot program described in this subsection is a program that applies one or more of the accountable care organization models described in section 1866E of the Social Security Act, as added by section 1301 of this Act.

(2) LIMITATION.—The pilot program shall operate for a period of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of the pilot program under this section, the Secretary may—

(1) waive the requirements of—

(A) section 1902(a)(1) of the Social Security Act (relating to statewideness);

(B) section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase the matching percentage for administrative expenditures up to—

(A) 90 percent (for the first 2 years of the pilot program); and

(B) 75 percent (for the next 3 years).

(d) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the pilot program under this section. In conducting such evaluation, the Secretary shall use the criteria used under subsection (g)(1) of section 1866E of the Social Security Act (as inserted by section 1301 of this Act) to evaluate pilot programs under such section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

SEC. 1730B. FQHC COVERAGE.

Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) is amended—

(1) by striking ''or'' at the end of clause (iii);

(2) by striking the semicolon at the end of clause (iv) and inserting '', and''; and

(3) by inserting after clause (iv) the following new clause:

''(v) is receiving a grant under section 399Z–1 of the Public Health Service Act;''.

Subtitle D—Coverage

SEC. 1731. OPTIONAL MEDICAID COVERAGE OF LOW-INCOME HIV-INFECTED INDIVIDUALS.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 1714(a)(1), is amended—

(1) in subsection (a)(10)(A)(ii)—

(A) by striking ''or'' at the end of subclause (XIX);

(B) by adding ''or'' at the end of subclause (XX); and

(C) by adding at the end the following:

''(XXI) who are described in subsection (ii)(relating to HIV-infected individuals);''; and

(2) by adding at the end, as amended by sections 1703 and 1714(a), the following:

''(ii) Individuals described in this subsection are individuals not described in subsection (a)(10)(A)(i)—

''(1) who have HIV infection;

''(2) whose income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

''(3) whose resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.''.

(b) ENHANCED MATCH.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''section 1902(a)(10)(A)(ii)(XVIII)'' and inserting ''subclause (XVIII) or (XXI) of section 1902(a)(10)(A)(ii)''.

(c) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding paragraph (1)—

(1) by striking ''or'' at the end of clause (xii);

(2) by adding ''or'' at the end of clause (xiii); and

(3) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ii),''.

(d) EXEMPTION FROM FUNDING LIMITATION FOR TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following:

''(5) DISREGARDING MEDICAL ASSISTANCE FOR OPTIONAL LOW-INCOME HIV-INFECTED INDIVIDUALS.—The limitations under subsection (f) and the previous provisions of this subsection shall not apply to amounts expended for medical assistance for individuals described in section 1902(ii) who are only eligible for such assistance on the basis of section 1902(a)(10)(A)(ii)(XXI).''.

(e) EFFECTIVE DATE; SUNSET.—The amendments made by this section shall apply to expenditures for calendar quarters beginning on or after the date of the enactment of this Act, and before January 1, 2013, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1732. EXTENDING TRANSITIONAL MEDICAID ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)), as amended by section 5004(a)(1) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

SEC. 1733. REQUIREMENT OF 12-MONTH CONTINUOUS COVERAGE UNDER CERTAIN CHIP PROGRAMS.

(a) IN GENERAL.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended by adding at the end the following new paragraph:

''(6) REQUIREMENT FOR 12-MONTH CONTINUOUS ELIGIBILITY.—In the case of a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), the plan shall provide for implementation under this title of the 12-month continuous eligibility option described in section 1902(e)(12) for targeted low-income children whose family income is below 200 percent of the poverty line.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations (and redeterminations) of eligibility made on or after January 1, 2010.

SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF COVERAGE WAITING PERIODS FOR CERTAIN CHILDREN.

(a) IN GENERAL.—Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended—

(1) in subparagraph (B)—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(v) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a child described in subparagraph (C).''; and

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

''(C) DESCRIPTION OF CHILDREN NOT SUBJECT TO WAITING PERIOD.—For purposes of this paragraph, a child described in this subparagraph is a child who, on the date an application is submitted for such child for child health assistance under this title, meets any of the following requirements:

''(i) INFANTS AND TODDLERS.—The child is under two years of age.

''(ii) LOSS OF GROUP HEALTH PLAN COVERAGE.—The child previously had private health insurance coverage through a group health plan or health insurance coverage offered through an employer and lost such coverage due to—

''(I) termination of an individual's employment;

''(II) a reduction in hours that an individual works for an employer;

''(III) elimination of an individual's retiree health benefits; or

''(IV) termination of an individual's group health plan or health insurance coverage offered through an employer.

''(iii) UNAFFORDABLE PRIVATE COVERAGE.—

''(I) IN GENERAL.—The family of the child demonstrates that the cost of health insurance coverage (including the cost of premiums, co-payments, deductibles, and other cost sharing) for such family exceeds 10 percent of the income of such family.

''(II) DETERMINATION OF FAMILY INCOME.—For purposes of subclause (I), family income shall be determined in the same manner specified by the State for purposes of determining a child's eligibility for child health assistance under this title.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as of the date that is 90 days after the date of the enactment of this Act.

SEC. 1735. ADULT DAY HEALTH CARE SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) EFFECTIVE DATE.—Subsection (a) shall apply with respect to services provided on or after October 1, 2008.

SEC. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the designated Federal program defined in paragraph (3)(C) (relating to the Medicaid program), section 401(a) and paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.''.

(b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—Section 403(d) of such Act (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking ''or'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(3) an individual described in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C).''.

(c) DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting a comma;

(2) in paragraph (7), by striking the period at the end and inserting '', or''; and

(3) by adding at the end the following:

''(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C) (relating to the Medicaid program).''.

SEC. 1737. CONTINUING REQUIREMENT OF MEDICAID COVERAGE OF NONEMERGENCY TRANSPORTATION TO MEDICALLY NECESSARY SERVICES.

(a) REQUIREMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (21)'' and inserting '', (21), and (30)''; and

(2) in subparagraph (C)(iv), by striking ''and (17)'' and inserting '', (17), and (30)''.

(b) DESCRIPTION OF SERVICES.—Section 1905(a) of such Act (42 U.S.C. 1395d(a)), as amended by sections 1713(a)(1) and 1724(a)(1), is amended—

(1) in paragraph (29), by striking ''and'' at the end;

(2) by redesignating paragraph (30) as paragraph (31) and by striking the comma at the end and inserting a semicolon; and

(3) by inserting after paragraph (29) the following new paragraph:

''(30) nonemergency transportation to medically necessary services, consistent with the requirement of section 431.53 of title 42, Code of Federal Regulations, as in effect as of June 1, 2008; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to transportation on or after such date.

SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME IN PROVIDING CONTINUED MEDICAID COVERAGE FOR CERTAIN INDIVIDUALS WITH EXTREMELY HIGH PRESCRIPTION COSTS.

Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by section 203(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new paragraph:

''(14)(A) At the option of the State, in the case of an individual with extremely high prescription drug costs described in subparagraph (B) who has been determined (without the application of this paragraph) to be eligible for medical assistance under this title, the State may, in redetermining the individual's eligibility for medical assistance under this title, disregard any family income of the individual to the extent such income is less than an amount that is specified by the State and does not exceed the amount specified in subparagraph (C), or, if greater, income equal to the cost of the orphan drugs described in subparagraph (B)(iii).

''(B) An individual with extremely high prescription drug costs described in this subparagraph for a 12-month period is an individual—

''(i) who is covered under health insurance or a health benefits plan that has a maximum lifetime limit of not less than $1,000,000 which includes all prescription drug coverage;

''(ii) who has exhausted all available prescription drug coverage under the plan as of the beginning of such period;

''(iii) who incurs (or is reasonably expected to incur) on an annual basis during the period costs for orphan drugs in excess of the amount specified in subparagraph (C) for the period; and

''(iv) whose annual family income (determined without regard to this paragraph) as of the beginning of the period does not exceed 75 percent of the amount incurred for such drugs (as described in clause (iii)).

''(C) The amount specified in this subparagraph for a 12-month period beginning in—

''(i) 2009 or 2010, is $200,000; or

''(ii) a subsequent year, is the amount specified in clause (i) (or this subparagraph) for the previous year increased by the annual rate of increase in the medical care component of the consumer price index (U.S. city average) for the 12-month period ending in August of the previous year.

Any amount computed under clause (ii) that is not a multiple of $1,000 shall be rounded to the nearest multiple of $1,000.

''(D) In applying this paragraph, amounts incurred for prescription drugs for cosmetic purposes shall not be taken into account.

''(E) With respect to an individual described in subparagraph (A), notwithstanding section 1916, the State plan—

''(i) shall provide for the application of cost-sharing that is at least nominal as determined under section 1916; and

''(ii) may provide, consistent with section 1916A, for such additional cost-sharing as does not exceed a maximum level of cost-sharing that is specified by the Secretary and is adjusted by the Secretary on an annual basis.

''(F) A State electing the option under this paragraph shall provide for a determination on an individual's application for continued medical assistance under this title within 30 days of the date the application if filed with the State.

''(G) In this paragraph:

''(i) The term 'orphan drugs' means prescription drugs designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) as a drug for a rare disease or condition.

''(ii) The term 'health benefits plan' includes coverage under a plan offered under a State high risk pool.''.

SEC. 1739. PROVISIONS RELATING TO COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS).

(a) COORDINATION WITH CLASS PROVISIONS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), 1783(a), and 1907(b), is amended—

(1) in paragraph (80), by striking ''and'' at the end;

(2) in paragraph (81), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (81) the following:

''(82) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish.''.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by subsection (a), is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82), the following:

''(83) provide that, not later than 2 years after the date of enactment of this paragraph, each State shall—

''(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

''(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

''(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.''.

(c) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act.''; and

(2) in paragraph (3)—

(A) by striking ''2010'' and inserting ''2015''; and

(B) by adding at the end the following: ''In addition to the amount appropriated under the previous sentence, there are authorized to be appropriated to carry out this subsection, $7,000,000 for each of fiscal years 2011, 2012, and 2013.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2011.

SEC. 1739A. SENSE OF CONGRESS REGARDING COMMUNITY FIRST CHOICE OPTION TO PROVIDE MEDICAID COVERAGE OF COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.

It is the sense of Congress that States should be allowed to elect under their Medicaid State plans under title XIX of the Social Security Act to implement a Community First Choice Option under which—

(1) coverage of community-based attendant services and supports furnished in homes and communities is available, at an individual's option, to individuals who would otherwise qualify for Medicaid institutional coverage under the respective State plan;

(2) such supports and services include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks;

(3) the Federal matching assistance percentage (FMAP) under such title for medical assistance for such supports and services is enhanced;

(4) States, consistent with minimum federal standards, ensure quality of such supports and services; and

(5) States collect and provide data to the Secretary of Health and Human Services on

the cost and effectiveness and quality of supports and services provided through such option.

Subtitle E—Financing

SEC. 1741. PAYMENTS TO PHARMACISTS.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as 130 percent of the weighted average (determined on the basis of manufacturer utilization) of monthly average manufacturer prices. Nothing in the previous sentence shall be construed as preventing the Secretary from performing such calculation using a smoothing process in order to reduce significant variations from month to month as a result of rebates, discounts, and other pricing practices, such as in the manner such a process is used by the Secretary in determining the average sales price of a drug or biological under section 1847A.''

(2) DEFINITION OF AMP.—Section 1927(k)(1)(B) of such Act (42 U.S.C. 1396r–8(k)(1)(B)) is amended—

(B) in the heading, by striking ''EXTENDED TO WHOLESALERS'' and inserting ''AND OTHER PAYMENTS''; and

(C) by striking ''regard to'' and all that follows through the period and inserting the following: ''regard to—

''(i) customary prompt pay discounts extended to wholesalers;

''(ii) bona fide service fees paid by manufacturers;

''(iii) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

''(iv) sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or long term care providers, provided that these rebates, discounts, or price concessions are not passed through to retail pharmacies;

''(v) sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions in order to obtain an accurate AMP for the drug. Such a determination shall not be subject to judicial review; or

''(vi) rebates, discounts, and other price concessions required to be provided under agreements under subsections (f) and (g) of section 1860D–2(f).''.

(3) MANUFACTURER REPORTING REQUIREMENTS.—Section 1927(b)(3)(A) of such Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) by striking the period at the end of clause (iii) and inserting ''; and''; and

(C) by inserting after clause (iii) the following new clause:

''(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug.''.

(4) AUTHORITY TO PROMULGATE REGULATION.—The Secretary of Health and Human Services may promulgate regulations to clarify the requirements for upper payment limits and for the determination of the average manufacturer price in an expedited manner. Such regulations may become effective on an interim final basis, pending opportunity for public comment.

(5) PHARMACY REIMBURSEMENTS THROUGH DECEMBER 31, 2010.—The specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through December 31, 2010, for purposes of the availability of Federal financial participation for such payments.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), in the matter preceding subclause (I), by inserting ''month of a'' after ''each''; and

(B) in the last sentence, by striking ''and shall,'' and all that follows up to the period; and

(2) in subparagraph (D)(v), by inserting ''weighted'' before ''average manufacturer prices''.

SEC. 1742. PRESCRIPTION DRUG REBATES.

(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF NEW FORMULATIONS.—In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

''(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

''(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).

In this subparagraph, the term 'line extension' means, with respect to a drug, a new formulation of the drug, such as an extended release formulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.

(b) INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—

(A) in subclause (IV), by striking ''and'' at the end;

(B) in subclause (V)—

(i) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

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

(C) by adding at the end the following new subclause:

''(VI) after December 31, 2009, is 23.1 percent.''.

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

''(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

''(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

''(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by section 1742(b)(1) of the Affordable Health Care for America Act, taking into account the additional drugs included under the amendments made by section 1743 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

''(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under 1116(d).''.

SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (xi), by striking ''and'' at the end;

(2) in clause (xii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as specified by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1927(b)(2)(A) and to the Secretary under section 1927(b)(2)(C), information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this subsection.''.

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r-8) is amended——

(1) in the first sentence of subsection (b)(1)(A), by inserting before the period at the end the following: '', including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs'';

(2) in subsection (b)(2), by adding at the end the following new subparagraph:

''(C) REPORTING ON MMCO DRUGS.—On a quarterly basis, each State shall report to the Secretary the total amount of rebates in dollars received from pharmacy manufacturers for drugs provided to individuals enrolled with Medicaid managed care organizations that contract under section 1903(m) and such other information as the Secretary may require to carry out paragraph (1)(C) with respect to such rebates.''; and

(3) in subsection (j)—

(A) in the heading by striking ''EXEMPTION'' and inserting ''SPECIAL RULES''; and

(B) in paragraph (1), by striking ''are not subject to the requirements of this section'' and inserting ''are subject to the requirements of this section unless such drugs are subject to discounts under section 340B of the Public Health Service Act''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2010, and shall apply to drugs dispensed on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1701(a)(3)(B), 1711(a), and 1713(a), is amended by adding at the end the following new subsection:

''(bb) PAYMENT FOR GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The term 'medical assistance' includes payment for costs of graduate medical education consistent with this subsection, whether provided in or outside of a hospital.

''(2) SUBMISSION OF INFORMATION.—For purposes of paragraph (1) and section 1902(a)(13)(A)(v), payment for such costs is not consistent with this subsection unless—

''(A) the State submits to the Secretary, in a timely manner and on an annual basis specified by the Secretary, information on total payments for graduate medical education and how such payments are being used for graduate medical education, including—

''(i) the institutions and programs eligible for receiving the funding;

''(ii) the manner in which such payments are calculated;

''(iii) the types and fields of education being supported;

''(iv) the workforce or other goals to which the funding is being applied;

''(v) State progress in meeting such goals; and

''(vi) such other information as the Secretary determines will assist in carrying out paragraphs (3) and (4); and

''(B) such expenditures are made consistent with such goals and requirements as are established under paragraph (4).

''(3) REVIEW OF INFORMATION.—The Secretary shall make the information submitted under paragraph (2) available to the Advisory Committee on Health Workforce Evaluation and Assessment (established under section 2261 of the Public Health Service Act). The Secretary and the Advisory Committee shall independently review the information submitted under paragraph (2), taking into account State and local workforce needs.

''(4) SPECIFICATION OF GOALS AND REQUIREMENTS.—The Secretary shall specify by rule, initially published by not later than December 31, 2011—

''(A) program goals for the use of funds described in paragraph (1), taking into account recommendations of the such Advisory Committee and the goals for approved medical residency training programs described in section 1886(h)(1)(B); and

''(B) requirements for use of such funds consistent with such goals.

Such rule may be effective on an interim basis pending revision after an opportunity for public comment.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)), as amended by section 1721(a)(1)(A), is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) by striking the semicolon in clause (iv) and inserting '', and''; and

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

''(v) in the case of hospitals and at the option of a State, such rates may include, to the extent consistent with section 1905(bb), payment for graduate medical education; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act. Nothing in this section shall be construed as affecting payments made before such date under a State plan under title XIX of the Social Security Act for graduate medical education.

SEC. 1745. NURSING FACILITY SUPPLEMENTAL PAYMENT PROGRAM.

(a) TOTAL AMOUNT AVAILABLE FOR PAYMENTS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') to carry out this section $6,000,000,000, of which the following amounts shall be available for obligation in the following years:

(A) $1,500,000,000 shall be available beginning in 2010.

(B) $1,500,000,000 shall be available beginning in 2011.

(C) $1,500,000,000 shall be available beginning in 2012.

(D) $1,500,000,000 shall be available beginning in 2013.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until all eligible dually-certified facilities (as defined in subsection (b)(3)) have been reimbursed for underpayments under this section during cost reporting periods ending during calendar years 2010 through 2013.

(3) LIMITATION OF AUTHORITY.—The Secretary may not make payments under this section that exceed the funds appropriated under paragraph (1).

(4) DISPOSITION OF REMAINING FUNDS INTO MIF.—Any funds appropriated under paragraph (1) which remain available after the application of paragraph (2) shall be deposited into the Medicaid Improvement Fund under section 1941 of the Social Security Act.

(b) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the amounts available for obligation in a year under subsection (a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall pay the amount determined under paragraph (2) directly to an eligible dually-certified facility for the purpose of providing funding to reimburse such facility for furnishing quality care to Medicaid-eligible individuals.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the payment amount determined under this paragraph for a year for an eligible dually-certified facility shall be an amount determined by the Secretary as reported on the facility's latest available Medicare cost report.

(B) LIMITATION ON PAYMENT AMOUNT.—In no case shall the payment amount for an eligible dually-certified facility for a year under subparagraph (A) be more than the payment deficit described in paragraph (3)(D) for such facility as reported on the facility's latest available Medicare cost report.

(C) PRO-RATA REDUCTION.—If the amount available for obligation under subsection (a) for a year (as reduced by allowable administrative costs under this section) is insufficient to ensure that each eligible dually-certified facility receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each such facility in a pro-rata manner to ensure that the entire amount available for such payments for the year be paid.

(D) NO REQUIRED MATCH.—The Secretary may not require that a State provide matching funds for any payment made under this subsection.

(3) ELIGIBLE DUALLY-CERTIFIED FACILITY DEFINED.—For purposes of this section, the term ''eligible dually-certified facility'' means, for a cost reporting period ending during a year (beginning no earlier than 2010) that is covered by the latest available Medicare cost report, a nursing facility that meets all of the following requirements:

(A) The facility is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act during the entire year.

(B) The base Medicaid payment rate (excluding any supplemental payments) to the facility is not less than the base Medicaid payment rate (excluding any supplemental payments) to such facility as of June 16, 2009.

(C) As reported on the facility's latest Medicare cost report—

(i) the Medicaid share of patient days for such facility is not less than 60 percent of the combined Medicare and Medicaid share of resident days for such facility; and

(ii) the combined Medicare and Medicaid share of resident days for such facility, as reported on the facility's latest available Medicare cost report, is not less than 75 percent of the total resident days for such facility.

(D) The facility has received Medicaid reimbursement (including any supplemental payments) for the provision of covered services to Medicaid eligible individuals, as reported on the facility's latest available Medicare cost report, that is significantly less (as determined by the Secretary) than the allowable costs (as determined by the Secretary) incurred by the facility in providing such services.

(E) The facility is not in the highest quartile of costs costs per day, as determined by the Secretary and as adjusted for case mix, wages, and type of facility.

(F) The facility provides quality care, as determined by the Secretary, to—

(i) Medicaid eligible individuals; and

(ii) individuals who are entitled to items and services under part A of title XVIII of the Social Security Act.

(G) In the most recent standard survey available, the facility was not cited for any immediate jeopardy deficiencies as defined by the Secretary.

(H) In the most recent standard survey available, the facility maintains an appropriate staffing level to attain or maintain the highest practicable well-being of each resident as defined by the Secretary.

(I) The facility complies with all the requirements, as determined by the Secretary, contained in sections 1411 through 1416 and the amendments made by such sections.

(J) The facility was not listed as a Centers for Medicare & Medicaid Services Special Focus Facility (SFF) nor as a SFF on a State-based list.

(4) FREQUENCY OF PAYMENT.—Payment of an amount under this subsection to an eligible dually-certified facility shall be made for a year in a lump sum or in such periodic payments in such frequency as the Secretary determines appropriate.

(5) DIRECT PAYMENTS.—Such payment—

(A) shall be made directly by the Secretary to an eligible dually-certified facility or a contractor designated by such facility; and

(B) shall not be made through a State.

(c) ADMINISTRATION.—

(1) ANNUAL APPLICATIONS; DEADLINES.—The Secretary shall establish a process, including

deadlines, under which facilities may apply on an annual basis to qualify as eligible dually-certified facilities for payment under subsection (b).

(2) CONTRACTING AUTHORITY.—The Secretary may enter into one or more contracts with entities for the purpose of implementation of this section.

(3) LIMITATION.—The Secretary may not spend more than 0.75 percent of the amount made available under subsection (a) in any year on the costs of administering the program of payments under this section for the year.

(4) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, the provisions of this section.

(5) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of—

(A) the determination of the eligibility of a facility for payments under subsection (b); or

(B) the determination of the amount of any payment made to a facility under such subsection.

(d) ANNUAL REPORTS.—The Secretary shall submit an annual report to the committees with jurisdiction in the Congress on payments made under subsection (b). Each such report shall include information on—

(1) the facilities receiving such payments;

(2) the amount of such payments to such facilities; and

(3) the basis for selecting such facilities and the amount of such payments.

(e) REFERENCE TO REPORT.—For report by the Medicaid and CHIP Payment and Access Commission on the adequacy of payments to nursing facilities under the Medicaid program, see section 1900(b)(2)(B) of the Social Security Act, as amended by section 1784.

(f) DEFINITIONS.—For purposes of this section:

(1) DUALLY-CERTIFIED FACILITY.—The term ''dually-certified facility'' means a facility that is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act.

(2) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance, with respect to nursing facility services (as defined in section 1905(f) of the Social Security Act), under title XIX of the such Act.

(3) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 1746. REPORT ON MEDICAID PAYMENTS.

Section 1902 of the Social Security Act (42 U.S.C. 1396), as amended by sections 1703(a), 1714(a), and 1731(a), is amended by adding at the end the following new subsection:

''(jj) REPORT ON MEDICAID PAYMENTS.—Each year, on or before a date determined by the Secretary, a State participating in the Medicaid program under this title shall submit to the Administrator of the Centers for Medicare & Medicaid Services—

''(1) information on the determination of rates of payment to providers for covered services under the State plan, including—

''(A) the final rates;

''(B) the methodologies used to determine such rates; and

''(C) justifications for the rates; and

''(2) an explanation of the process used by the State to allow providers, beneficiaries and their representatives, and other concerned State residents a reasonable opportunity to review and comment on such rates, methodologies, and justifications before the State made such rates final.''.

SEC. 1747. REVIEWS OF MEDICAID.

(a) GAO STUDY ON FMAP.—.

(1) STUDY.—The Comptroller General of the United States shall conduct a study regarding federal payments made to the State Medicaid programs under title XIX of the Social Security Act for the purposes of making recommendations to Congress.

(2) REPORT.—Not later than February 15, 2011, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under paragraph (1) and the effect on the federal government, States, providers, and beneficiaries of—

(A) removing the 50 percent floor, or 83 percent ceiling, or both, in the Federal medical assistance percentage under section 1905(b)(1) of the Social Security Act; and

(B) revising the current formula for such Federal medical assistance percentage to better reflect State fiscal capacity and State effort to pay for health and long-term care services and to better adjust for national or regional economic downturns.

(b) GAO STUDY ON MEDICAID ADMINISTRATIVE COSTS..—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the administration of the Medicaid program by the Department of Health and Human Services, State Medicaid agencies, and local government agencies. The report shall address the following issues:

(A) The extent to which federal funds for each administrative function, such as survey and certification and claims processing, are being used effectively and efficiently.

(B) The administrative functions on which federal Medicaid funds are expended and the amounts of such expenditures (whether spent directly or by contract).

(2) REPORT.—Not later than February 15, 2011, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under paragraph (1).

SEC. 1748. EXTENSION OF DELAY IN MANAGED CARE ORGANIZATION PROVIDER TAX ELIMINATION.

Effective as if included in the enactment of section 6051 of the Deficit Reduction Act of 2005 (Public Law 109–171), subsection (b)(2)(A) of such section is amended by striking ''October 1, 2009'' and inserting ''October 1, 2010''.

SEC. 1749. EXTENSION OF ARRA INCREASE IN FMAP.

Section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) in subsection (a)(3), by striking ''first calendar quarter'' and inserting ''first 3 calendar quarters'';

(2) in subsection (b)(2), by inserting before the period at the end the following: ''and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010'';

(3) in subsection (c)(4)(C)(ii), by striking ''December 2009'' and ''January 2010'' and inserting ''June 2010'' and ''July 2010'', respectively;

(4) in subsection (d), by inserting ''ending before October 1, 2010'' after ''entire fiscal years'' and after ''with respect to fiscal years'';

(5) in subsection (g)(1), by striking ''September 30, 2011'' and inserting ''December 31, 2011''; and

(6) in subsection (h)(3), by striking ''December 31, 2010'' and inserting ''June 30, 2011''.

Subtitle F—Waste, Fraud, and Abuse

SEC. 1751. HEALTH CARE ACQUIRED CONDITIONS.

(a) MEDICAID NON-PAYMENT FOR CERTAIN HEALTH CARE-ACQUIRED CONDITIONS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) with respect to amounts expended for services related to the presence of a condition that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) and for any health care acquired condition determined as a non-covered service under title XVIII.''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(G) of such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by striking ''and (17)'' and inserting ''(17), and (25)''.

(c) PERMISSION TO INCLUDE ADDITIONAL HEALTH CARE-ACQUIRED CONDITIONS.—Nothing in this section shall prevent a State from including additional health care-acquired conditions for non-payment in its Medicaid program under title XIX of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after January 1, 2010.

SEC. 1752. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICAID INTEGRITY PROGRAM.

Section 1936(c)(2)) of the Social Security Act (42 U.S.C. 1396u–7(c)(2)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C) the following new subparagraph:

''(D) For the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities.''.

SEC. 1753. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

Section 1902(a) of such Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1), 1703, and 1729, is further amended—

(1) in paragraph (75), by striking at the end ''and'';

(2) in paragraph (76), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (76) the following new paragraph:

''(77) provide that any provider or supplier (other than a physician or nursing facility) providing services under such plan shall, subject to paragraph (5) of section 1874(d), establish a compliance program described in paragraph (1) of such section in accordance with such section.''.

SEC. 1754. OVERPAYMENTS.

(a) IN GENERAL.—Section 1903(d)(2)(C) of the Social Security Act (42 U.S.C. 1396b(d)(2)(C)) is amended—

(1) in the first sentence, by inserting ''(or of 1 year in the case of overpayments due to fraud)'' after ''60 days''; and

(2) in the second sentence, by striking ''the 60 days'' and inserting ''such period''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply in the case of overpayments discovered on or after the date of the enactment of this Act.

SEC. 1755. MANAGED CARE ORGANIZATIONS.

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as amended by section 1743(a)(3), is amended—

(A) by striking ''and'' at the end of clause (xii);

(B) by striking the period at the end of clause (xiii) and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(xiv) such contract has a medical loss ratio, as determined in accordance with a

methodology specified by the Secretary that is a percentage (not less than 85 percent) as specified by the Secretary.''.

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (H) through (L) as subparagraphs (I) through (M); and

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

''(H) Section 1903(m)(2)(A)(xiv) (relating to application of minimum loss ratios), with respect to comparable contracts under this title.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHIP IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN OR CHILD HEALTH PLAN.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions are permitted with respect to exclusion under sections 1128(b)(3)(C) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII, any other State plan under this title, or any child health plan under title XXI,''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)) is amended by inserting before the period at the end the following: ''and section 1902(a)(39) (relating to exclusion and termination of participation)''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after January 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1), 1703(a), 1729, and 1753, is further amended—

(1) in paragraph (76), by striking at the end ''and'';

(2) in paragraph (77), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (77) the following new paragraph:

''(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period.''.

(b) CHILD HEALTH PLAN REQUIREMENT.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)), as amended by section 1756(b), is amended by striking ''section 1902(a)(39)'' and inserting ''sections 1902(a)(39) and 1902(a)(78)''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after January 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after July 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for detection of waste, fraud, and abuse''.

SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, and 1757(a), is further amended—

(1) in paragraph (77); by striking at the end ''and'';

(2) in paragraph (78), by striking the period at the end and inserting ''and''; and

(3) by inserting after paragraph (78) the following new paragraph:

''(79) provide that any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary under section 1866(j)(1)(D).''.

(b) DENIAL OF PAYMENT.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by section 1751, is amended—

(1) by striking ''or'' at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting ''; or''; and

(3) by inserting after paragraph (25) the following new paragraph:

''(26) with respect to any amount paid to a billing agent, clearinghouse, or other alternate payee that is not registered with the State and the Secretary as required under section 1902(a)(79).''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to claims submitted on or after January 1, 2012, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1760. DENIAL OF PAYMENTS FOR LITIGATION-RELATED MISCONDUCT.

(a) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by sections 1751(a) and 1759(b), is amended—

(1) by striking ''or'' at the end of paragraph (25);

(2) by striking the period at the end of paragraph (26) and inserting ''; or''; and

(3) by inserting after paragraph (26) the following new paragraph:

''(27) with respect to any amount expended—

''(A) on litigation in which a court imposes sanctions on the State, its employees, or its counsel for litigation-related misconduct; or

''(B) to reimburse (or otherwise compensate) a managed care entity for payment of legal expenses associated with any action in which a court imposes sanctions on the managed care entity for litigation-related misconduct.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to amounts expended on or after January 1, 2010.

SEC. 1761. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

''(4) Not later than September 1, 2010, the Secretary shall do the following:

''(A) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

''(B) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

''(C) Notify States of—

''(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

''(ii) how States are to incorporate such methodologies into claims filed under this title.

''(D) Submit a report to Congress that includes the notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B).''.

Subtitle G—Payments to the Territories

SEC. 1771. PAYMENT TO TERRITORIES.

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(2) in subsection (g)(1), by striking ''With respect to'' and inserting ''Subject to subsection (h), with respect to''; and

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

''(h) ADDITIONAL INCREASE FOR FISCAL YEARS 2011 THROUGH 2019.—Subject to section 347(b)(1) of the Affordable Health Care for America Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsections (f) and (g) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa shall be increased by the following amounts:

''(1) For Puerto Rico, for fiscal year 2011, $727,600,000; for fiscal year 2012, $775,000,000; for fiscal year 2013, $850,000,000; for fiscal year 2014, $925,000,000; for fiscal year 2015, $1,000,000,000; for fiscal year 2016, $1,075,000,000; for fiscal year 2017, $1,150,000,000; for fiscal year 2018, $1,225,000,000; and for fiscal year 2019, $1,396,400,000.

''(2) For the Virgin Islands, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(3) For Guam, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(4) For the Northern Mariana Islands, for fiscal year 2011, $13,500,000; fiscal year 2012, $14,500,000; for fiscal year 2013, $15,500,000; for fiscal year 2014, $16,500,000; for fiscal year 2015, $17,500,000; for fiscal year 2016, $18,500,000; for fiscal year 2017, $19,500,000; for fiscal year 2018, $21,000,000; and for fiscal year 2019, $22,000,000.

''(5) For American Samoa, fiscal year 2011, $22,000,000; fiscal year 2012, $23,687,500; for fiscal year 2013, $24,687,500; for fiscal year 2014, $25,687,500; for fiscal year 2015, $26,687,500; for fiscal year 2016, $27,687,500; for fiscal year 2017, $28,687,500; for fiscal year 2018, $29,687,500; and for fiscal year 2019, $30,687,500.''.

(b) REPORT ON ACHIEVING MEDICAID PARITY PAYMENTS BEGINNING WITH FISCAL YEAR 2020.—

(1) IN GENERAL.—Not later than October 1, 2013, the Secretary of Health and Human Services shall submit to Congress a report that details a plan for the transition of each territory to full parity in Medicaid with the 50 States and the District of Columbia in fiscal year 2020 by modifying their existing Medicaid programs and outlining actions the Secretary and the governments of each territory must take by fiscal year 2020 to ensure parity in financing. Such report shall include what the Federal medical assistance percentages would be for each territory if the formula applicable to the 50 States were applied. Such report shall also include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided for in section 1108 of the Social Security Act (42 U.S.C. 1308) should be increased any time before fiscal year 2020 due to any factors that the Secretary deems relevant.

(2) PER CAPITA DATA.—As part of such report the Secretary shall include information about per capita income data that could be used to calculate Federal medical assistance percentages under section 1905(b) of the Social Security Act, under section 1108(a)(8)(B) of such Act, for each territory on how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical assistance percentages can be calculated for the territories beginning in fiscal year 2020 to ensure parity with the 50 States.

(3) SUBSEQUENT REPORTS.—The Secretary shall submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined in the plan submitted under paragraph (1).

(c) APPLICATION OF FMAP FOR ADDITIONAL FUNDS.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following sentence: ''Notwithstanding the first sentence of this subsection and any other provision of law, for fiscal years 2011 through 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of section 5001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and the District for calendar quarters during such fiscal years for which such subsections apply.''.

(d) WAIVERS.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa''; and

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning with fiscal year 2011.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide nonmonetary technical assistance to the governments of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in upgrading their existing computer systems in order to anticipate meeting reporting requirements necessary to implement the plan contained in the report under subsection (b)(1).

Subtitle H—Miscellaneous

SEC. 1781. TECHNICAL CORRECTIONS.

(a) TECHNICAL CORRECTION TO SECTION 1144 OF THE SOCIAL SECURITY ACT.—The first sentence of section 1144(c)(3) of the Social Security Act (42 U.S.C. 1320b—14(c)(3)) is amended—

(1) by striking ''transmittal''; and

(2) by inserting before the period the following: ''as specified in section 1935(a)(4)''.

(b) CLARIFYING AMENDMENT TO SECTION 1935 OF THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the Social Security Act (42 U.S.C. 1396u—5(a)(4)), as amended by section 113(b) of Public Law 110–275, is amended—

(1) by striking the second sentence;

(2) by redesignating the first sentence as a subparagraph (A) with appropriate indentation and with the following heading: ''IN GENERAL.—'';

(3) by adding at the end the following subparagraphs:

''(B) FURNISHING MEDICAL ASSISTANCE WITH REASONABLE PROMPTNESS.—For the purpose of a State's obligation under section 1902(a)(8) to furnish medical assistance with reasonable promptness, the date of the electronic transmission of low-income subsidy program data, as described in section 1144(c), from the Commissioner of Social Security to the State Medicaid Agency, shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

''(C) DETERMINING AVAILABILITY OF MEDICAL ASSISTANCE.—For the purpose of determining when medical assistance will be made available, the State shall consider the date of the individual's application for the low income subsidy program to constitute the date of filing for benefits under the Medicare Savings Program.''.

(c) EFFECTIVE DATE RELATING TO MEDICAID AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY APPLICATION AND DATA TRANSMITTAL.—The amendments made by subsections (a) and (b) shall be effective as if included in the enactment of section 113(b) of Public Law 110–275.

(d) TECHNICAL CORRECTION TO SECTION 605 OF CHIPRA.—Section 605 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) is amended by striking ''legal residents'' and inserting ''lawfully residing in the United States''.

(e) TECHNICAL CORRECTION TO SECTION 1905 OF THE SOCIAL SECURITY ACT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

(f) CLARIFYING AMENDMENT TO SECTION 1115 OF THE SOCIAL SECURITY ACT.—Section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)) is amended by adding at the end the following: ''If an experimental, pilot, or demonstration project that relates to title XIX is approved pursuant to any part of this subsection, such project shall be treated as part of the State plan, all medical assistance provided on behalf of any individuals affected by such project shall be medical assistance provided under the State plan, and all provisions of this Act not explicitly waived in approving such project shall remain fully applicable to all individuals receiving benefits under the State plan.''.

SEC. 1782. EXTENSION OF QI PROGRAM.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is amended—

(1) by striking ''sections 1933 and'' and by inserting ''section''; and

(2) by striking ''December 2010'' and inserting ''December 2012''.

(b) ELIMINATION OF FUNDING LIMITATION.—

(1) IN GENERAL.—Section 1933 of such Act (42 U.S.C. 1396u–3) is amended—

(A) in subsection (a), by striking ''who are selected to receive such assistance under subsection (b)'';

(B) by striking subsections (b), (c), (e), and (g);

(C) in subsection (d), by striking ''furnished in a State'' and all that follows and inserting ''the Federal medical assistance percentage shall be equal to 100 percent.''; and

(D) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(2) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2011.

SEC. 1783. ASSURING TRANSPARENCY OF INFORMATION.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), and 1907(b), is amended—

(1) by striking ''and'' at the end of paragraph (79);

(2) by striking the period at the end of paragraph (80) and inserting ''; and''; and

(3) by inserting after paragraph (80) the following new paragraph:

''(81) provide that the State will establish and maintain laws, in accordance with the requirements of section 1921A, to require disclosure of information on hospital charges and quality and to make such information available to the public and the Secretary.''; and

(4) by inserting after section 1921 the following new section:

''HOSPITAL PRICE TRANSPARENCY

''SEC. 1921A. (a) IN GENERAL.—The requirements referred to in section 1902(a)(81) are that the laws of a State must—

''(1) require reporting to the State (or its agent) by each hospital located therein, of information on,—

''(A) the charges for the most common inpatient and outpatient hospital services;

''(B) the Medicare and Medicaid reimbursement amount for such services; and

''(C) if the hospitals allows for or provides reduced charges for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determination and the contact information for the specific department of a hospital that responds to such inquiries;

''(2) provide for notice to individuals seeking or requiring such services of the availability of information on charges described in paragraph (1);

''(3) provide for timely access to such information, including at least through an Internet website, by individuals seeking or requiring such services; and

''(4) provide for timely access to information regarding the quality of care at each hospital made publicly available in accordance with section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), section 1139A, or section 1139B.

The Secretary shall consult with stakeholders (including those entities in section 1808(d)(6) and the National Governors Association) through a formal process to obtain guidance prior to issuing implementing policies under this section.

''(b) HOSPITAL DEFINED.—For purposes of this section, the term 'hospital' means an institution that meets the requirements of paragraphs (1) and (7) of section 1861(e) and includes those to which section 1820(c) applies.''.

(b) EFFECTIVE DATE; ADMINISTRATION.—

(1) IN GENERAL.—Except as provided in paragraphs (2)(B) and section 1790, the amendments made by subsection (a) shall take effect on October 1, 2010.

(2) EXISTING PROGRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall establish a process by which a State with an existing program may certify to the Secretary that its program satisfies the requirements of section 1921A of the Social Security Act, as inserted by subsection (a).

(B) 2-YEAR PERIOD TO BECOME IN COMPLIANCE.—States that, as of the date of the enactment of this Act, administer hospital price transparency policies that do not meet such requirements shall have 2 years from such date to make necessary modifications to come into compliance and shall not be regarded as failing to comply with such requirements during such 2-year period.

SEC. 1784. MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.

(a) REPORT ON NURSING FACILITY PAYMENT POLICIES.—Section 1900(b) of the Social Security Act (42 U.S.C. 1396(b)) is amended by adding at the end the following new paragraph:

''(10) REPORTS ON SPECIAL TOPICS ON PAYMENT POLICIES.—

''(A) NURSING FACILITY PAYMENT POLICIES.—Not later than January 1, 2012, the Commission shall submit to Congress a report on nursing facility payment policies under Medicaid that includes—

''(i) information on the difference between the amount paid by each State to nursing facilities in such State under the Medicaid program under this title and the cost to such facilities of providing efficient quality care to Medicaid eligible individuals;

''(ii) an evaluation of patient outcomes and quality as a result of the supplemental payments under section 1745(b) of the Affordable Health Care for America Act; and

''(iii) whether adjustments should be made under the Medicaid program to the rates that States pay skilled nursing facilities to ensure that such rates are sufficient to provide efficient quality care to Medicaid eligible individuals.''.

(b) PEDIATRIC SUBSPECIALIST PAYMENT POLICIES.—Section 1900(b)(10) of the Social Security Act, as added by subsection (a) is amended by adding at the end the following new subparagraph:

''(B) PEDIATRIC SUBSPECIALIST PAYMENT POLICIES.—Not later than January 1, 2011, the Commission shall submit to Congress a report on payment policies for pediatric subspecialist services under Medicaid that includes—

''(i) a comprehensive review of each State's Medicaid payment rates for inpatient and outpatient pediatric speciality services;

''(ii) a comparison, on a State-by-State basis, of the rates under clause (i) to Medicare payments for similar services;

''(iii) information on any limitations in patient access to pediatric speciality care, such as delays in receiving care or wait times for receiving care;

''(iv) an analysis of the extent to which low Medicaid payment rates in any State contributes to limits in access to pediatric subspecialty services in such State; and

''(v) recommendations to ameliorate any problems found with such payment rates or with access to such services.''.

(c) ADDITIONAL AMENDMENTS.—

(1) COMMISSION STATUS.—Section 1900(a) of the Social Security Act is amended by inserting ''as an agency of Congress'' after ''established''.

(2) EXPANSION OF SCOPE.—Section 1900(b)(1)(A) of the Social Security Act is amended by striking ''children's access'' and inserting ''access by low-income children and other eligible individuals''.

(3) CHANGE IN REPORT DEADLINES.—Subparagraphs (C) and (D) of section 1900(b)(1) of such Act are amended by striking ''2010'' and inserting ''2011'' each place it appears.

(4) REPORT IN HEALTH REFORM.—Section 1900(b)(2) of such Act is amended—

(A) in subparagraph (A)(i), by striking ''skilled'';

(B) by striking subparagraph (B);

(C) by redesignating subparagraph (C) as subparagraph (B); and

(D) by adding at the end the following new subparagraph:

''(C) IMPLEMENTATION OF HEALTH REFORM.—The implementation of the provisions of the Affordable Health Care for America Act that relate to Medicaid or CHIP by the Secretary, the Health Choices Commissioner, and the States, including the effect of such implementation on the access to needed health care items and services by low-income individuals and families.''.

(5) CLARIFICATION OF MEMBERSHIP.—Section 1900(c)(2)(B) of such Act is amended by striking ''consumers'' and inserting ''individuals''.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) CURRENT AUTHORIZATION.—Section 1900(f)(2) of such Act is amended—

(i) in the heading, by inserting ''OF APPROPRIATIONS PRIOR TO 2010'' after ''AUTHORIZATION''; and

(ii) by striking ''There are'' and inserting ''Prior to January 1, 2010, there are''

(B) FUTURE AUTHORIZATION.—Section 1900(f) of such Act is further amended by adding at the end the following new paragraph: after the period the following:

''(3) AUTHORIZATION OF APPROPRIATIONS FOR 2010.—Beginning on January 1, 2010, there is authorized to be appropriated $11,800,000 to carry out the provisions of this section. Such funds shall remain available until expended.''.

SEC. 1785. OUTREACH AND ENROLLMENT OF MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Not later than 12 months after date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance regarding standards and best practices for conducting outreach to inform eligible individuals about healthcare coverage under Medicaid under title XIX of the Social Security Act or for child health assistance under CHIP under title XXI of such Act, providing assistance to such individuals for enrollment in applicable programs, and establishing methods or procedures for eliminating application and enrollment barriers. Such guidance shall include provisions to ensure that outreach, enrollment assistance, and administrative simplification efforts are targeted specifically to vulnerable populations such as children, unaccompanied homeless youth, victims of abuse or trauma, individuals with mental health or substance related disorders, and individuals with HIV/AIDS. Guidance issued pursuant to this section relating to methods to increase outreach and enrollment provided for under titles XIX and XXI of the Social Security Act shall specifically target such vulnerable and underserved populations and shall include, but not be limited to, guidance on outstationing of eligibility workers, express lane eligibility, residence requirements, documentation of income and assets, presumptive eligibility, continuous eligibility, and automatic renewal.

(b) IMPLEMENTATION.—In implementing the requirements under subsection (a), the Secretary may use such authorities as are available under law and may work with such entities as the Secretary deems appropriate to facilitate effective implementation of such programs. Not later than 2 years after the enactment of this Act and annually thereafter, the Secretary shall review and report to Congress on progress in implementing targeted outreach, application and enrollment assistance, and administrative simplification methods for such vulnerable and underserved populations as are specified in subsection (a).

SEC. 1786. PROHIBITIONS ON FEDERAL MEDICAID AND CHIP PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this title shall change current prohibitions against Federal Medicaid and CHIP payments under titles XIX and XXI of the Social Security Act on behalf of individuals who are not lawfully present in the United States.

SEC. 1787. DEMONSTRATION PROJECT FOR STABILIZATION OF EMERGENCY MEDICAL CONDITIONS BY INSTITUTIONS FOR MENTAL DISEASES.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide reimbursement under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to an individual who—

(1) has attained age 21, but has not attained age 65;

(2) is eligible for medical assistance under such plan; and

(3) requires such medical assistance to stabilize an emergency medical condition.

(b) IN-STAY REVIEW.—The Secretary shall establish a mechanism for in-stay review to

determine whether or not the patient has been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of these benefits under the project through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) APPLICATION.—Upon approval of an application submitted by a State described in paragraph (2), the State shall be an eligible State for purposes of conducting a demonstration project under this section.

(2) STATE DESCRIBED.—States shall be selected by the Secretary in a manner so as to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2010.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2012.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2012.

(4) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a).

(f) REPORTS.—

(1) ANNUAL PROGRESS REPORTS.—The Secretary shall submit annual reports to Congress on the progress of the demonstration project conducted under this section.

(2) FINAL REPORT AND RECOMMENDATION.—An evaluation shall be conducted of the demonstration project's impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program. This evaluation shall include collection of baseline data for one-year prior to the initiation of the demonstration project as well as collection of data from matched comparison states not participating in the demonstration. The evaluation measures shall include the following:

(A) A determination, by State, as to whether the demonstration project resulted in increased access to inpatient mental health services under the Medicaid program and whether average length of stays were longer (or shorter) for individuals admitted under the demonstration project compared with individuals otherwise admitted in comparison sites.

(B) An analysis, by State, regarding whether the demonstration project produced a significant reduction in emergency room visits for individuals eligible for assistance under the Medicaid program or in the duration of emergency room lengths of stay.

(C) An assessment of discharge planning by participating hospitals that ensures access to further (non-emergency) inpatient or residential care as well as continuity of care for those discharged to outpatient care.

(D) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care) under the plan as contrasted with the comparison areas.

(E) Data on the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(F) A recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis.

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of title XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ''Federal medical assistance percentage'' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ''medical assistance'' has the meaning given to that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) STABILIZED.—The term ''stabilized'' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 1788. APPLICATION OF MEDICAID IMPROVEMENT FUND.

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended by striking ''from the Fund'' and all that follows and inserting ''from the Fund, only such amounts as may be appropriated or otherwise made available by law.''.

SEC. 1789. TREATMENT OF CERTAIN MEDICAID BROKERS.

Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(b)(4)) is amended—

(1) in the matter before subparagraph (A), by inserting after ''respect to the broker'' the following: ''(or, in the case of subparagraph (A) and subparagraph (B)(i), if the Inspector General of Department of Health and Human Services finds that the broker has established and maintains procedures to ensure the independence of its enrollment activities from the interests of any managed care entity or provider)''; and

(2) in subparagraph (B)—

(A) by inserting ''(i)'' after ''either''; and

(B) by inserting ''(ii)'' after ''health care provider or''.

SEC. 1790. RULE FOR CHANGES REQUIRING STATE LEGISLATION.

In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet an additional requirement imposed by an amendment made by this title, the State plan shall not be regarded as failing to comply with the requirements of such title XIX solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE VIII—REVENUE-RELATED PROVISIONS

SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Paragraph (19) of section 6103(1) of the Internal Revenue Code of 1986 is amended to read as follows:

''(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—

''(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall be disclosed to officers and employees of the Social Security Administration, with respect to any taxpayer identified by the Commissioner of Social Security—

''(i) return information for the applicable year from returns with respect to wages (as defined in section 3121(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

''(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year,

''(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self-employment, on such return,

''(iv) if the individual is a married individual filing a separate return for the applicable year, the social security number (if reasonably available) of the spouse on such return,

''(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, and subchapter S corporations of the individual's spouse on such return, and

''(vi) such other return information relating to the individual (or the individual's spouse in the case of a joint return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

''(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer information records.

''(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

''(i) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy, and

''(ii) any individual the Social Security Administration has identified as a spouse of an individual described in clause (i).

''(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act for use in outreach efforts under section 1144 of the Social Security Act.''.

(b) SAFEGUARDS.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by striking ''(19),'' each place it appears, and

(2) by striking ''or (17)'' each place it appears and inserting ''(17), or (19)''.

(c) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''(19),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of the enactment of this Act.

SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.

(a) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—

''(1) IN GENERAL.—There are hereby appropriated to the Trust Fund the following:

''(A) For fiscal year 2010, $90,000,000.

''(B) For fiscal year 2011, $100,000,000.

''(C) For fiscal year 2012, $110,000,000.

''(D) For each fiscal year beginning with fiscal year 2013—

''(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(ii) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

''(2) ADMINISTRATIVE PROVISIONS.—

''(A) TRANSFERS FROM OTHER TRUST FUNDS.—The amounts appropriated by subparagraphs (A), (B), (C), and (D)(ii) of paragraph (1) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

''(B) APPROPRIATIONS NOT SUBJECT TO FISCAL YEAR LIMITATION.—The amounts appropriated by paragraph (1) shall not be subject to any fiscal year limitation.

''(C) PERIODIC TRANSFERS, ESTIMATES, AND ADJUSTMENTS.—Except as provided in subparagraph (A), the provisions of section 9601 shall apply to the amounts appropriated by paragraph (1).

''(c) FAIR SHARE PER CAPITA AMOUNT.—

''(1) COMPUTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2013) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

''(B) ALTERNATIVE COMPUTATION.—

''(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

''(ii) DEFAULT AMOUNT.—The default amount under this clause for—

''(I) fiscal year 2013 is equal to $2; or

''(II) a subsequent year is equal to the default amount under this clause for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

''(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

''(d) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and Human Services to carry out section 1181 of the Social Security Act.

''(2) ALLOCATION FOR COMMISSION.—The following amounts in the CERTF shall be available, without the need for further appropriations and without fiscal year limitation, to the Commission to carry out the activities of the Comparative Effectiveness Research Commission established under section 1181(b) of the Social Security Act:

''(A) For fiscal year 2010, $7,000,000.

''(B) For fiscal year 2011, $9,000,000.

''(C) For each fiscal year beginning with 2012, 2.6 percent of the total amount appropriated to the CERTF under subsection (b) for the fiscal year.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

''Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.''.

(b) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(1) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(2) CLERICAL AMENDMENTS.—

(A) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(B) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 1901. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

Part B of title IV of the Social Security Act (42 U.S.C. 621–629i) is amended by adding at the end the following:

''Subpart 3—Support for Quality Home Visitation Programs

''SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

''(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

''(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, at such time and in such manner as the Secretary may require, an application for the grant that includes the following:

''(1) DESCRIPTION OF HOME VISITATION PROGRAMS.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be supported by a grant made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

''(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

''(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

''(B) the number and types of families who are receiving services under the programs;

''(C) the sources and amount of funding provided to the programs;

''(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services; and

''(E) training and technical assistance activities designed to achieve or support the goals of the programs.

''(3) ASSURANCES.—Assurances from the State that—

''(A) in supporting home visitation programs using funds provided under this section, the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

''(B) the State will reserve 5 percent of the grant funds for training and technical assistance to the home visitation programs using such funds;

''(C) in supporting home visitation programs using funds provided under this section, the State will promote coordination and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

''(D) home visitation programs supported using such funds will, when appropriate, provide referrals to other programs serving children and families; and

''(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

''(4) OTHER INFORMATION.—Such other information as the Secretary may require.

''(c) ALLOTMENTS.—

''(1) INDIAN TRIBES.—From the amount reserved under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian tribe that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the amount so reserved as the number of children in the Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

''(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not an Indian tribe and that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the remainder of the amount so appropriated as the number of children in the State whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such States whose families have income that does not exceed 200 percent of the poverty line.

''(3) REALLOTMENTS.—The amount of any allotment to a State under a paragraph of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section shall be available for reallotment using the allotment methodology specified in that paragraph. Any amount so reallotted to a State is deemed part of the allotment of the State under this subsection.

''(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection for a fiscal year if the Secretary finds that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

''(e) PAYMENT OF GRANT.—

''(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under subsection (m), in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

''(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term 'reimbursable percentage' means, with respect to a fiscal year—

''(A) 85 percent, in the case of fiscal year 2010;

''(B) 80 percent, in the case of fiscal year 2011; or

''(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year.

''(f) ELIGIBLE EXPENDITURES.—

''(1) IN GENERAL.—In this section, the term 'eligible expenditures'—

''(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

''(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development;

''(ii) employ well-trained and competent staff, maintain high quality supervision, provide for ongoing training and professional development, and show strong organizational capacity to implement such a program;

''(iii) establish appropriate linkages and referrals to other community resources and supports;

''(iv) monitor fidelity of program implementation to ensure that services are delivered according to the specified model; and

''(v) provide parents with—

''(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);

''(II) knowledge of realistic expectations of age-appropriate child behaviors;

''(III) knowledge of health and wellness issues for children and parents;

''(IV) modeling, consulting, and coaching on parenting practices;

''(V) skills to interact with their child to enhance age-appropriate development;

''(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

''(VII) activities designed to help parents become full partners in the education of their children;

''(B) includes expenditures for training, technical assistance, and evaluations related to the programs; and

''(C) does not include any expenditure with respect to which a State has submitted a claim for payment under any other provision of Federal law.

''(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

''(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that do not adhere to a model of home visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

''(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term 'applicable percentage' means, with respect to a fiscal year—

''(i) 60 percent for fiscal year 2010;

''(ii) 55 percent for fiscal year 2011;

''(iii) 50 percent for fiscal year 2012;

''(iv) 45 percent for fiscal year 2013; or

''(v) 40 percent for fiscal year 2014.

''(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

''(h) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

''(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

''(A) the Secretary waives the requirement; or

''(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

''(i) STATE REPORTS.—Each State to which a grant is made under this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

''(1) the services delivered by the programs that received funds from the grant;

''(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

''(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

''(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

''(5) the annual cost of implementing the program, including the cost per family served under the program;

''(6) the outcomes experienced by recipients of services through the program;

''(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

''(8) the indicators and methods used to monitor whether the program is being implemented as designed; and

''(9) other information as determined necessary by the Secretary.

''(j) EVALUATION.—

''(1) IN GENERAL.—The Secretary shall, by grant or contract, provide for the conduct of an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

''(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

''(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

''(2) REPORTS TO THE CONGRESS.—

''(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

''(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

''(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

''(1) The high need communities targeted by States for programs carried out under this section.

''(2) The service delivery models used in the programs receiving funds provided under this section.

''(3) The characteristics of the programs, including—

''(A) the qualifications and demographic characteristics of program staff; and

''(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

''(4) The outcomes reported by the programs.

''(5) The research-based instruction, materials, and activities being used in the activities funded under the grant.

''(6) The training and technical activities, including on-going professional development, provided to the programs.

''(7) The annual costs of implementing the programs, including the cost per family served under the programs.

''(8) The indicators and methods used by States to monitor whether the programs are being been implemented as designed.

''(l) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (m), the Secretary shall reserve—

''(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (j), and the provision to States of training and technical assistance, including the dissemination of best practices in early childhood home visitation; and

''(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

''(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

''(1) $50,000,000 for fiscal year 2010;

''(2) $100,000,000 for fiscal year 2011;

''(3) $150,000,000 for fiscal year 2012;

''(4) $200,000,000 for fiscal year 2013; and

''(5) $250,000,000 for fiscal year 2014.

''(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 431(a) shall apply.''.

SEC. 1905. IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES.

Title XI of the Social Security Act is amended by inserting after section 1150 the following new section:

''IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

''SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (g)). The office or program shall—

''(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A and B of title XVIII, under the Medicare Advantage program under part C of such title, and under title XIX;

''(2) identify areas of such policies where better coordination and protection could improve care and costs; and

''(3) issue guidance to States regarding improving such coordination and protection.

''(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

''(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

''(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

''(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

''(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

''(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

''(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

''(2) Development of methods to facilitate access to post-acute and community-based services and to identify actions that could lead to better coordination of community-based care.

''(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income subsidy program under section 1860D–14 to identify methods to more efficiently and effectively reach and enroll dual eligibles.

''(4) An assessment of communication strategies for dual eligibles to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1–800–MEDICARE, and the Medicare handbook.

''(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors related to enrollee satisfaction with services and care delivery.

''(6) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

''(7) Support for coordination of State and Federal contracting and oversight for dual coordination programs supportive of the goals described in subsection (b).

''(8) Support for State Medicaid agencies through the provision of technical assistance for Medicare and Medicaid coordination initiatives designed to improve acute and long-term care for dual eligibles.

''(9) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

''(10) Coordination of activities relating to Medicare Advantage plans under 1859(b)(6)(B)(ii) and Medicaid.

''(d) REPORTING.—The Office or program shall work with relevant State agencies and any appropriate quality measurement entities to improve and coordinate reporting requirements for Medicare and Medicaid. In addition, the Office or program shall seek to minimize duplication in reporting requirements, where appropriate, and to identify opportunities to combine assessment requirements, where appropriate. The Office or program shall seek to identify quality metrics and assessment requirements that facilitate comparisons of the quality of care received by beneficiaries enrolled in or entitled to benefits under fee-for-service Medicare, the Medicare Advantage program, fee-for-service Medicaid, and Medicaid managed care, and combinations thereof (including integrated Medicare-Medicaid programs for dual eligibles).

''(e) ENDORSEMENT.—The Secretary shall seek endorsement by the entity with a contract under section 1890(a) of quality measures and benchmarks developed under this section.

''(f) CONSULTATION WITH STAKEHOLDERS.—The Office or program shall consult with relevant stakeholders, including dual eligible beneficiaries representatives for dual eligible beneficiaries, health plans, providers, and relevant State agencies, in the development of policies related to integrated Medicare-Medicaid programs for dual eligibles.

''(g) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit to Congress a report on progress in activities conducted under this section.

''(h) DEFINITIONS.—In this section:

''(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who is dually eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

''(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.''.

SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE DISEASES AND CONDITIONS.

(a) INITIAL ASSESSMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program and, to the extent possible, assess the diseases and conditions that could become cost-intensive for Medicare in the future. In conducting the assessment, the Secretary shall include the input of relevant research agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

(2) REPORT.—Not later than January 1, 2011, the Secretary shall transmit a report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions, Finance, and Appropriations of the Senate on the assessment conducted under paragraph (1). Such report shall—

(A) include the assessment of current and future trends of cost-intensive diseases and conditions described in such paragraph;

(B) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified; and

(C) include recommendations concerning research in the Department of Health and Human Services that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

(b) UPDATES OF ASSESSMENT.—Not later than January 1, 2013, and biennially thereafter, the Secretary shall—

(1) review and update the assessment and recommendations described in subsection (a)(1); and

(2) submit a report described in subsection (a)(2) to the Committees specified in subsection (a)(2) on such updated assessment and recommendations.

SEC. 1907. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

''CENTER FOR MEDICARE AND MEDICAID INNOVATION

''SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

''(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to applicable individuals defined in paragraph (4)(A).

''(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

''(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, clinical and analytical experts with expertise in medicine and health care management, and States. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

''(4) DEFINITIONS.—In this section:

''(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

''(i) an individual who is enrolled under part B and entitled to benefits under part A of title XVIII;

''(ii) an individual who is eligible for medical assistance under title XIX; or

''(iii) an individual who meets the criteria of both clauses (i) and (ii).

''(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall give preference to testing models for which, as determined by the Administrator of the Centers for Medicare & Medicaid Services and using such input from outside the Centers as the Administrator determines appropriate, there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Administrator shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.

''(B) APPLICATION TO OTHER DEMONSTRATIONS.—The Secretary shall operate the demonstration programs under sections 1222 and 1236 of the Affordable Health Care for America Act through the CMI in accordance with the rules applicable under this section, including those relating to evaluations, terminations, and expansions.

''(3) BUDGET NEUTRALITY.—

''(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

''(B) TERMINATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under the applicable title, certifies), after testing has begun, that the model is expected to—

''(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under such title;

''(ii) reduce spending under such titles without reducing the quality of care; or

''(iii) do both.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(4) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

''(i) the quality of care furnished under the model, including through the use of patient-level outcomes measures; and

''(ii) the changes in spending under the applicable titles by reason of the model.

The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion.

''(B) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures developed under section 1192(c)(1).

''(5) TESTING PERIOD.—In no case shall a model be tested under this subsection for more than a 7-year period.

''(c) EXPANSION OF MODELS (PHASE II).—The Secretary may expand the duration and the scope of a model that is being tested under subsection (b) (including implementation on a nationwide basis), to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected—

''(A) to improve the quality of patient care without increasing spending under the applicable titles;

''(B) to reduce spending under applicable titles without reducing the quality of care; or

''(C) to do both;

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or not result in any increase in) net program spending under applicable titles; and

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

''(d) IMPLEMENTATION.—

''(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902 and 1903(m) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

''(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the selection of models for testing or expansion under this section;

''(B) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(C) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(D) determinations about expansion of the duration and scope of a model under subsection (c) including the determination that a model is not expected to meet criteria described in paragraphs (1) or (2) of such subsection.

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the testing and evaluation of models or expansion of such models under this section.

''(4) FUNDING FOR TESTING ITEMS AND SERVICES AND ADMINISTRATIVE COSTS.—

''(A) ADDITIONAL BENEFITS.—There shall be available until expended, equally divided from the Federal Supplementary Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund for payments for additional benefits for items and services under models tested under subsection (b) not otherwise covered under this title and applicable to benefits under this title, and for researching, designing, implementing, and evaluating such models, $350,000,000 for fiscal year 2010, $440,000,000 for fiscal year 2011, $550,000,000 for fiscal year 2012, and, for a subsequent fiscal year, the amount determined under this subparagraph for the preceding fiscal year increased by the annual percentage rate of increase in total expenditures under this title for the subsequent fiscal year as estimated in the latest available Annual Report of the Board of Trustees as described in section 1841(b)(2).

''(B) MEDICAID.—For administrative costs of the Centers for Medicare & Medicaid Services for administering this section with respect to title XIX, from any amounts in the Treasury not otherwise appropriated there are appropriated to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this subparagraph for a fiscal year shall be available until expended.

''(e) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the payment models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary believes are appropriate for legislative action to facilitate the development and expansion of successful payment models.''.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), and 1759(a), is amended—

(1) in paragraph (78), by striking ''and'' at the end;

(2) in paragraph (79), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (79) the following new paragraph:

''(80) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

SEC. 1908. APPLICATION OF EMERGENCY SERVICES LAWS.

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ''EMTALA'').

SEC. 1909. DISREGARD UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM OF COMPENSATION FOR PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.

(a) INCOME DISREGARD.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(1) by striking ''and'' at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting ''; and''; and

(3) by adding at the end the following:

''(26) The first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial to test a treatment for a rare disease or condition (within the meaning of section 5(b)(2) of the Orphan Drug Act (Public Law 97–414)), that—

''(A) has been reviewed and approved by an institutional review board that—

''(i) is established to protect the rights and welfare of human subjects participating in research; and

''(ii) meet the standards for such bodies set forth in part 46 of title 45, Code of Federal Regulations; and

''(B) meets the standards for protection of human subjects for clinical research (as set forth in such part).''.

(b) RESOURCE DISREGARD.—Section 1613(a) of such Act (42 U.S.C. 1382b(a)) is amended—

(1) by striking ''and'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; and''; and

(3) by inserting after paragraph (16) the following:

''(17) the first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial, as described in section 1612(b)(26).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for calendar months beginning after the earlier of—

(1) the date the Commissioner of Social Security promulgates regulations to carry out the amendments; or

(2) the 180-day period that begins with the date of the enactment of this Act.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

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

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.

(a) ESTABLISHMENT OF FUNDS.—

(1) IN GENERAL.—Subject to section 2003, there is hereby established in the Treasury a separate account to be known as the ''Public Health Investment Fund'' (referred to in this section and section 2003 as the ''Fund'').

(2) FUNDING.—

(A) There shall be deposited into the Fund—

(i) for fiscal year 2011, $4,600,000,000;

(ii) for fiscal year 2012, $5,600,000,000;

(iii) for fiscal year 2013, $6,900,000,000;

(iv) for fiscal year 2014, $7,800,000,000; and

(v) for fiscal year 2015, $9,000,000,000.

(B) Amounts deposited into the Fund shall be derived from general revenues of the Treasury only for the fiscal years set forth in this section, and amounts appropriated from the Fund shall remain available until expended.

(b) AUTHORIZATION OF APPROPRIATIONS FROM THE FUND.—

(1) NEW FUNDING.—

(A) IN GENERAL.—Subject to section 2003, amounts in the Fund are authorized to be appropriated for carrying out activities under designated public health provisions.

(B) DESIGNATED PROVISIONS.—For purposes of this paragraph, the term ''designated public health provisions'' means the provisions for which amounts are authorized to be appropriated under section 330(s), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division.

(2) BASELINE FUNDING.—

(A) IN GENERAL.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (1)) for a fiscal year only if (excluding any amounts in or appropriated from the Fund) the amounts specified in subparagraph (B) for the fiscal year involved are equal to or greater than the amounts specified in subparagraph (B) for fiscal year 2008.

(B) AMOUNTS SPECIFIED.—The amounts specified in this subparagraph, with respect to a fiscal year are the amounts appropriated (excluding any amounts in or appropriated from the Fund) for the following:

(i) Community health centers (including funds appropriated under the authority of section 330 of the Public Health Service Act (42 U.S.C. 254b)).

(ii) The National Health Service Corps Program (including funds appropriated under the authority of section 338 of such Act (42 U.S.C. 254k)).

(iii) The National Health Service Corps Scholarship and Loan Repayment Programs (including funds appropriated under the authority of section 338H of such Act (42 U.S.C. 254q)).

(iv) Primary care education programs (including funds appropriated under the authority of sections 736, 740, 741, and 747 of such Act (42 U.S.C. 293, 293d, and 293k)).

(v) Sections 761 and 770 of such Act (42 U.S.C. 294n and 295e).

(vi) Nursing workforce development (including funds appropriated under the authority of title VIII of such Act (42 U.S.C. 296 et seq.)).

(vii) The National Center for Health Statistics (including funds appropriated under the authority of sections 304, 306, 307, and 308 of such Act (42 U.S.C. 242b, 242k, 242l, and 242m)).

(viii) The Agency for Healthcare Research and Quality (including funds made available under the authority of title IX of such Act (42 U.S.C. 299 et seq.)).

SEC. 2003. DEFICIT NEUTRALITY.

(a) AVAILABILITY.—Funds appropriated or made available pursuant to sections 330(s), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division, are only available for the purposes set forth in this Act. Appropriations shall not be available and are precluded from obligation for any other purpose.

(b) ESTIMATION OF BUDGETARY IMPACT.—For the purposes of estimating the spending effects of this Act, the authorization of appropriations from the Fund, to the extent amounts in the Fund are derived from the general revenues of the Treasury, shall be treated as new direct spending and attributed to this Act.

(c) BUDGETARY TREATMENT.—For the purposes of section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, the Fund, to the extent amounts in the Fund are derived from the general revenues of the Treasury, and not in excess of amounts subsequently appropriated from the Fund, shall be deemed to be included on the list of appropriations referenced under section 250(c)(17) of that Act.

TITLE I—COMMUNITY HEALTH CENTERS

SEC. 2101. INCREASED FUNDING.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (r)(1)—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(C) by inserting at the end the following:

''(F) such sums as may be necessary for each of fiscal years 2013 through 2015.''; and

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

''(s) ADDITIONAL FUNDING.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) For fiscal year 2011, $1,000,000,000.

''(2) For fiscal year 2012, $1,500,000,000.

''(3) For fiscal year 2013, $2,500,000,000.

''(4) For fiscal year 2014, $3,000,000,000.

''(5) For fiscal year 2015, $4,000,000,000.''.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

SEC. 2201. NATIONAL HEALTH SERVICE CORPS.

(a) FULFILLMENT OF OBLIGATED SERVICE REQUIREMENT THROUGH HALF-TIME SERVICE.—

(1) WAIVERS.—Subsection (i) of section 331 (42 U.S.C. 254d) is amended—

(A) in paragraph (1), by striking ''In carrying out subpart III'' and all that follows through the period and inserting ''In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half-time.'';

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking ''less than full time'' each place it appears and inserting ''half time'';

(ii) in subparagraphs (C) and (F), by striking ''less than full-time service'' each place it appears and inserting ''half-time service''; and

(iii) by amending subparagraphs (D) and (E) to read as follows:

''(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

''(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

''(i) double the period of obligated service that would otherwise be required; or

''(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and''; and

(C) in paragraph (3), by striking ''In evaluating a demonstration project described in paragraph (1)'' and inserting ''In evaluating waivers issued under paragraph (1)''.

(2) DEFINITIONS.—Subsection (j) of section 331 (42 U.S.C. 254d) is amended by adding at the end the following:

''(5) The terms 'full time' and 'full-time' mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

''(6) The terms 'half time' and 'half-time' mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.''.

(b) REAPPOINTMENT TO NATIONAL ADVISORY COUNCIL.—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amended by striking ''Members may not be reappointed to the Council.''.

(c) LOAN REPAYMENT AMOUNT.—Section 338B(g)(2)(A) (42 U.S.C. 254l–1(g)(2)(A)) is amended by striking ''$35,000'' and inserting ''$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation,''.

(d) TREATMENT OF TEACHING AS OBLIGATED SERVICE.—Subsection (a) of section 338C (42

U.S.C. 254m) is amended by adding at the end the following: ''The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.''.

SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.

(a) NATIONAL HEALTH SERVICE CORPS PROGRAM.—Section 338 (42 U.S.C. 254k) is amended—

(1) in subsection (a), by striking ''2012'' and inserting ''2015''; and

(2) by adding at the end the following:

''(c) For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $63,000,000 for fiscal year 2011.

''(2) $66,000,000 for fiscal year 2012.

''(3) $70,000,000 for fiscal year 2013.

''(4) $73,000,000 for fiscal year 2014.

''(5) $77,000,000 for fiscal year 2015.''.

(b) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) is amended—

(1) in section 338H(a)—

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

(B) in paragraph (5), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(6) for each of fiscal years 2013 through 2015, such sums as may be necessary.''; and

(2) by inserting after section 338H the following:

''SEC. 338H–1. ADDITIONAL FUNDING.

''For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $254,000,000 for fiscal year 2011.

''(2) $266,000,000 for fiscal year 2012.

''(3) $278,000,000 for fiscal year 2013.

''(4) $292,000,000 for fiscal year 2014.

''(5) $306,000,000 for fiscal year 2015.''.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

SEC. 2211. FRONTLINE HEALTH PROVIDERS.

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

''Subpart XI—Health Professional Needs Areas

''SEC. 340H. IN GENERAL.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program, to be known as the Frontline Health Providers Loan Repayment Program, to address unmet health care needs in health professional needs areas through loan repayments under section 340I.

''(b) DESIGNATION OF HEALTH PROFESSIONAL NEEDS AREAS.—

''(1) IN GENERAL.—In this subpart, the term 'health professional needs area' means an area, population, or facility that is designated by the Secretary in accordance with paragraph (2).

''(2) DESIGNATION.—To be designated by the Secretary as a health professional needs area under this subpart:

''(A) In the case of an area, the area must be a rational area for the delivery of health services.

''(B) The area, population, or facility must have, in one or more health disciplines, specialties, or subspecialties for the population served, as determined by the Secretary—

''(i) insufficient capacity of health professionals; or

''(ii) high needs for health services, including services to address health disparities.

''(C) With respect to the delivery of primary health services, the area, population, or facility must not include a health professional shortage area (as designated under section 332), except that the area, population, or facility may include such a health professional shortage area in which there is an unmet need for such services.

''(c) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1) hold a degree in a course of study or program (approved by the Secretary) from a school defined in section 799B(1)(A) (other than a school of public health);

''(2) hold a degree in a course of study or program (approved by the Secretary) from a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary;

''(3) be enrolled as a full-time student—

''(A) in a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary, or a school described in paragraph (1); and

''(B) in the final year of a course of study or program, offered by such school or program and approved by the Secretary, leading to a degree in a discipline referred to in subparagraph (A) (other than a graduate degree in public health), (C), (D), or (E)(4) of section 799B(1);

''(4) be a practitioner described in section 1842(b)(18)(C) or 1848(k)(3)(B)(iii) or (iv) of the Social Security Act; or

''(5) be a practitioner in the field of respiratory therapy, medical technology, or radiologic technology.

''(d) DEFINITIONS.—In this subpart:

''(1) The term 'health disparities' has the meaning given to the term in section 3171.

''(2) The term 'primary health services' has the meaning given to such term in section 331(a)(3)(D).

''SEC. 340I. LOAN REPAYMENTS.

''(a) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall enter into contracts with individuals under which—

''(1) the individual agrees—

''(A) to serve as a full-time primary health services provider or as a full-time or part-time provider of other health services for a period of time equal to 2 years or such longer period as the individual may agree to;

''(B) to serve in a health professional needs area in a health discipline, specialty, or a subspecialty for which the area, population, or facility is designated as a health professional needs area under section 340H; and

''(C) in the case of an individual described in section 340H(c)(3) who is in the final year of study and who has accepted employment as a primary health services provider or provider of other health services in accordance with subparagraphs (A) and (B), to complete the education or training and maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training); and

''(2) the Secretary agrees to pay, for each year of such service, an amount on the principal and interest of the undergraduate or graduate educational loans (or both) of the individual that is not more than 50 percent of the average award made under the National Health Service Corps Loan Repayment Program under subpart III in that year.

''(b) PRACTICE SETTING.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, an accredited public or private nonprofit hospital, or any other health care entity, as deemed appropriate by the Secretary.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.

''(d) INSUFFICIENT NUMBER OF APPLICANTS.—If there are an insufficient number of applicants for loan repayments under this section to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of recruiting applicants and entering into contracts with individuals so as to ensure a sufficient number of participants in the National Health Service Corps for the following year.

''SEC. 340J. REPORT.

''The Secretary shall submit to the Congress an annual report on the program carried out under this subpart.

''SEC. 340K. ALLOCATION.

''Of the amount of funds obligated under this subpart each fiscal year for loan repayments—

''(1) 90 percent shall be for physicians and other health professionals providing primary health services; and

''(2) 10 percent shall be for health professionals not described in paragraph (1).''.

SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.

(a) IN GENERAL.—Section 735 (42 U.S.C. 292y) is amended—

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

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

''(f) DETERMINATION OF FINANCIAL NEED.—The Secretary—

''(1) may require, or authorize a school or other entity to require, the submission of financial information to determine the financial resources available to any individual seeking assistance under this subpart; and

''(2) shall take into account the extent to which such individual is financially independent in determining whether to require or authorize the submission of such information regarding such individual's family members.''.

(b) REVISED GUIDELINES.—The Secretary of Health and Human Services shall—

(1) strike the second sentence of section 57.206(b)(1) of title 42, Code of Federal Regulations; and

(2) make such other revisions to guidelines and regulations in effect as of the date of the enactment of this Act as may be necessary for consistency with the amendments made by paragraph (1).

SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, GERIATRICS, AND PHYSICIAN ASSISTANTS.

Section 747 (42 U.S.C. 293k) is amended—

(1) by amending the section heading to read as follows: ''**PRIMARY CARE TRAINING AND ENHANCEMENT**'';

(2) by redesignating subsection (e) as subsection (g); and

(3) by striking subsections (a) through (d) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a primary care training and capacity building program consisting of awarding grants and contracts under subsections (b) and (c).

''(b) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(A) to plan, develop, operate, or participate in an accredited professional training

program, including an accredited residency or internship program, in the field of family medicine, general internal medicine, general pediatrics, or geriatrics for medical students, interns, residents, or practicing physicians;

''(B) to provide financial assistance in the form of traineeships and fellowships to medical students, interns, residents, or practicing physicians, who are participants in any such program, and who plan to specialize or work in family medicine, general internal medicine, general pediatrics, or geriatrics;

''(C) to plan, develop, operate, or participate in an accredited program for the training of physicians who plan to teach in family medicine, general internal medicine, general pediatrics, or geriatrics training programs including in community-based settings;

''(D) to provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such programs and who plan to teach in a family medicine, general internal medicine, general pediatrics, or geriatrics training program; and

''(E) to plan, develop, operate, or participate in an accredited program for physician assistant education, and for the training of individuals who plan to teach in programs to provide such training.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be—

''(A) an accredited school of medicine or osteopathic medicine, public or nonprofit private hospital, or physician assistant training program;

''(B) a public or private nonprofit entity; or

''(C) a consortium of 2 or more entities described in subparagraphs (A) and (B).

''(c) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary shall make grants to or enter into contracts with eligible entities to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of family medicine, general internal medicine, general pediatrics, or geriatrics; or

''(B) programs that improve clinical teaching in such specialties.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be an accredited school of medicine or osteopathic medicine.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who provide primary care.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals).

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the health care needs of vulnerable populations.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given the term in section 3171.''.

SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) by redesignating section 748 as 749A; and

(2) by inserting after section 747 the following:

''SEC. 748. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.

''(a) PROGRAM.—The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants and contracts under this section.

''(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan and develop a new primary care residency training program, which may include—

''(A) planning and developing curricula;

''(B) recruiting and training residents and faculty; and

''(C) other activities designated to result in accreditation of such a program; or

''(2) to operate or participate in an established primary care residency training program, which may include—

''(A) planning and developing curricula;

''(B) recruitment and training of residents; and

''(C) retention of faculty.

''(c) ELIGIBLE ENTITY.—To be eligible to receive a grant or contract under subsection (b), an entity shall—

''(1) be designated as a recipient of payment for the direct costs of medical education under section 1886(k) of the Social Security Act;

''(2) be designated as an approved teaching health center under section 1502(d) of the Affordable Health Care for America Act and continuing to participate in the demonstration project under such section;

''(3) be an applicant for designation described in paragraph (1) or (2) and have demonstrated to the Secretary appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program; or

''(4) be eligible to be designated as described in paragraph (1) or (2), not be an applicant as described in paragraph (3), and have demonstrated appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program.

''(d) PREFERENCES.—In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—

''(1) support teaching programs that address the health care needs of vulnerable populations; or

''(2) are a Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act) or a rural health clinic (as defined in section 1861(aa)(2) of such Act).

''(e) ADDITIONAL PREFERENCES FOR ESTABLISHED PROGRAMS.—In awarding grants and contracts under subsection (b)(2), the Secretary shall give preference to entities that have a demonstrated record of training—

''(1) a high or significantly improved percentage of health professionals who provide primary care;

''(2) individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals); or

''(3) individuals who practice in settings having the principal focus of serving underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(f) PERIOD OF AWARDS.—

''(1) IN GENERAL.—The period of a grant or contract under this section—

''(A) shall not exceed 3 years for awards under subsection (b)(1); and

''(B) shall not exceed 5 years for awards under subsection (b)(2).

''(2) SPECIAL RULES.—

''(A) An award of a grant or contract under subsection (b)(1) shall not be renewed.

''(B) The period of a grant or contract awarded to an entity under subsection (b)(2) shall not overlap with the period of any grant or contact awarded to the same entity under subsection (b)(1).

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(h) DEFINITIONS.—In this section:

''(1) HEALTH DISPARITIES.—The term 'health disparities' has the meaning given the term in section 3171.

''(2) PRIMARY CARE RESIDENT.—The term 'primary care resident' has the meaning given the term in section 1886(h)(5)(H) of the Social Security Act.

''(3) PRIMARY CARE RESIDENCY TRAINING PROGRAM.—The term 'primary care residency training program' means an approved medical residency training program described in section 1886(h)(5)(A) of the Social Security Act for primary care residents that is—

''(A) in the case of entities seeking awards under subsection (b)(1), actively applying to be accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; or

''(B) in the case of entities seeking awards under subsection (b)(2), so accredited.

''(i) ALLOCATION OF FUNDS.—Of the amount appropriated pursuant to section 799C(a) for a fiscal year, not more than 17 percent of such amount shall be made available to carry out this section.''.

SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) in section 791(a)(1), by striking ''747 and 750'' and inserting ''747, 749, and 750''; and

(2) by inserting after section 748, as added, the following:

''SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

''(a) PROGRAM.—The Secretary shall establish a training program for oral health professionals consisting of awarding grants and contracts under this section.

''(b) SUPPORT AND DEVELOPMENT OF ORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in an accredited professional training program for oral health professionals;

''(2) to provide financial assistance to oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public health dentistry, or dental hygiene;

''(3) to plan, develop, operate, or participate in a program for the training of oral health professionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

''(4) to provide financial assistance in the form of traineeships and fellowships to oral health professionals who plan to teach in

general, pediatric, or public health dentistry or dental hygiene;

''(5) to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of general, pediatric, or public health dentistry; or

''(B) programs that improve clinical teaching in such specialties;

''(6) to plan, develop, operate, or participate in predoctoral and postdoctoral training in general, pediatric, or public health dentistry programs;

''(7) to plan, develop, operate, or participate in a loan repayment program for full-time faculty in a program of general, pediatric, or public health dentistry; and

''(8) to provide technical assistance to pediatric dental training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under this section, an entity shall be—

''(1) an accredited school of dentistry, training program in dental hygiene, or public or nonprofit private hospital;

''(2) a training program in dental hygiene at an accredited institution of higher education;

''(3) a public or private nonprofit entity; or

''(4) a consortium of—

''(A) 1 or more of the entities described in paragraphs (1) through (3); and

''(B) an accredited school of public health.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of oral health professionals who practice general, pediatric, or public health dentistry.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among oral health professionals).

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the oral health needs of vulnerable populations.

''(5) Providing instruction regarding the oral health status, oral health care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITIONS.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'oral health professional' means an individual training or practicing—

''(A) in general dentistry, pediatric dentistry, public health dentistry, or dental hygiene; or

''(B) another oral health specialty, as deemed appropriate by the Secretary.''.

SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Part F of title VII (42 U.S.C. 295j et seq.) is amended by adding at the end the following:

''SEC. 799C. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

''(a) PROMOTION OF PRIMARY CARE AND DENTISTRY.—For the purpose of carrying out subpart XI of part D of title III and sections 747, 748, and 749, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $240,000,000 for fiscal year 2011.

''(2) $253,000,000 for fiscal year 2012.

''(3) $265,000,000 for fiscal year 2013.

''(4) $278,000,000 for fiscal year 2014.

''(5) $292,000,000 for fiscal year 2015.''.

(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subsection (g)(1), as so redesignated, of section 747 (42 U.S.C. 293k) is amended by striking ''2002'' and inserting ''2015''.

SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS AND LOAN REPAYMENTS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effectiveness of scholarship and loan repayment programs under subparts III and XI of part D of title III of the Public Health Service Act, as amended or added by sections 2201 and 2211, including whether scholarships or loan repayments are more effective in—

(1) incentivizing physicians, and other providers, to pursue careers in primary care specialties;

(2) retaining such primary care providers; and

(3) encouraging such primary care providers to practice in underserved areas.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to the Congress a report on the results of the study under subsection (a).

Subtitle B—Nursing Workforce

SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) DEFINITIONS.—Section 801 (42 U.S.C. 296 et seq.) is amended—

(1) in paragraph (1), by inserting ''nurse-managed health centers,'' after ''nursing centers,''; and

(2) by adding at the end the following:

''(16) NURSE-MANAGED HEALTH CENTER.—The term 'nurse-managed health center'—

''(A) means a nurse-practice arrangement, managed by one or more advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and is associated with an accredited school of nursing, Federally qualified health center, or independent nonprofit health or social services agency; and

''(B) shall not be construed as changing State law requirements applicable to an advanced practice nurse or the authorized scope of practice of such a nurse.''.

(b) GRANTS FOR HEALTH PROFESSIONS EDUCATION.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking section 807.

(c) REPORTS.—Part A of title VIII (42 U.S.C. 296 et seq.) is amended by adding at the end the following:

''SEC. 809. REPORTS.

''The Secretary shall submit to the Congress a separate annual report on the activities carried out under each of sections 811, 821, 836, 846A, and 861.''.

(d) ADVANCED EDUCATION NURSING GRANTS.—Section 811(f) (42 U.S.C. 296j(f)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3) as paragraph (2); and

(3) in paragraph (2), as so redesignated, by striking ''that agrees'' and all that follows through the end and inserting: ''that agrees to expend the award—

''(A) to train advanced education nurses who will practice in health professional shortage areas designated under section 332; or

''(B) to increase diversity among advanced education nurses.''.

(e) NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.—Section 831 (42 U.S.C. 296p) is amended—

(1) in subsection (b), by amending paragraph (3) to read as follows:

''(3) providing coordinated care, quality care, and other skills needed to practice nursing; or''; and

(2) by striking subsection (e) and redesignating subsections (f) through (h) as subsections (e) through (g), respectively.

(f) STUDENT LOANS.—Subsection (a) of section 836 (42 U.S.C. 297b) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200'';

(3) by striking ''$13,000'' and inserting ''$17,000''; and

(4) by adding at the end the following: ''Beginning with fiscal year 2012, the dollar amounts specified in this subsection shall be adjusted by an amount determined by the Secretary on an annual basis to reflect inflation.''.

(g) LOAN REPAYMENT.—Section 846 (42 U.S.C. 297n) is amended—

(1) in subsection (a), by amending paragraph (3) to read as follows:

''(3) who enters into an agreement with the Secretary to serve for a period of not less than 2 years—

''(A) as a nurse at a health care facility with a critical shortage of nurses; or

''(B) as a faculty member at an accredited school of nursing;''; and

(2) in subsection (g)(1), by striking ''to provide health services'' each place it appears and inserting ''to provide health services or serve as a faculty member''.

(h) NURSE FACULTY LOAN PROGRAM.—Paragraph (2) of section 846A(c) (42 U.S.C. 297n–1(c)) is amended by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation;''.

(i) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.

(j) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by moving section 810 (relating to prohibition against discrimination by schools on the basis of sex) so that it follows section 809, as added by subsection (c);

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part H;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F; and

(9) in part I—

(A) by redesignating section 855 as section 861; and

(B) by redesignating part I as part G.

(k) FUNDING.—

(1) IN GENERAL.—Part H, as redesignated, of title VIII is amended by adding at the end the following:

"SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

''For the purpose of carrying out this title, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $115,000,000 for fiscal year 2011.

''(2) $122,000,000 for fiscal year 2012.

''(3) $127,000,000 for fiscal year 2013.

''(4) $134,000,000 for fiscal year 2014.

''(5) $140,000,000 for fiscal year 2015.''.

(2) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(A) SECTIONS 831, 846, 846A, AND 861.—Sections 831(g) (as so redesignated), 846(i)(1) (42 U.S.C. 297n(i)(1)), 846A(f) (42 U.S.C. 297n–1(f)), and 861(e) (as so redesignated) are amended by striking ''2007'' each place it appears and inserting ''2015''.

(B) SECTION 871.—Section 871, as so redesignated by subsection (j), is amended to read as follows:

"SEC. 871. FUNDING.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015.''.

Subtitle C—Public Health Workforce

SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.

Part D of title III (42 U.S.C. 254b et seq.), as amended by section 2211, is amended by adding at the end the following:

"Subpart XII—Public Health Workforce

"SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.

''(a) ESTABLISHMENT.—There is established, within the Service, the Public Health Workforce Corps (in this subpart referred to as the 'Corps'), for the purpose of ensuring an adequate supply of public health professionals throughout the Nation. The Corps shall consist of—

''(1) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate;

''(2) such civilian employees of the United States as the Secretary may appoint; and

''(3) such other individuals who are not employees of the United States.

''(b) ADMINISTRATION.—Except as provided in subsection (c), the Secretary shall carry out this subpart acting through the Administrator of the Health Resources and Services Administration.

''(c) PLACEMENT AND ASSIGNMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop a methodology for placing and assigning Corps participants as public health professionals. Such methodology may allow for placing and assigning such participants in State, local, and tribal health departments and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act).

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart II shall, except as inconsistent with this subpart, apply to the Public Health Workforce Corps in the same manner and to the same extent as such provisions apply to the National Health Service Corps established under section 331.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the programs carried out under this subpart.

"SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at an accredited graduate school or program of public health; or

''(B) have demonstrated expertise in public health and be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at—

''(i) an accredited graduate school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

''(ii) another accredited graduate school or program, as deemed appropriate by the Secretary;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps; and

''(3) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional, upon the completion of the course of study or program involved, for the period of obligated service described in subsection (c)(2)(E).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(3) shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will—

''(A) provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual shall pursue an approved course of study or program to prepare the individual to serve in the public health workforce; and

''(B) accept (subject to the availability of appropriated funds) the individual into the Corps;

''(2) an agreement on the part of the individual that the individual will—

''(A) accept provision of such scholarship to the individual;

''(B) maintain full-time or part-time enrollment in the approved course of study or program described in subsection (b)(1) until the individual completes that course of study or program;

''(C) while enrolled in the approved course of study or program, maintain an acceptable level of academic standing (as determined by the educational institution offering such course of study or program);

''(D) if applicable, complete a residency or internship; and

''(E) serve full-time as a public health professional for a period of time equal to the greater of—

''(i) 1 year for each academic year for which the individual was provided a scholarship under the Program; or

''(ii) 2 years; and

''(3) an agreement by both parties as to the nature and extent of the scholarship assistance, which may include—

''(A) payment of reasonable educational expenses of the individual, including tuition, fees, books, equipment, and laboratory expenses; and

''(B) payment of a stipend of not more than $1,269 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) per month for each month of the academic year involved, with the dollar amount of such a stipend determined by the Secretary taking into consideration whether the individual is enrolled full-time or part-time.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the scholarship program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established under section 338A.

"SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) have a graduate degree from an accredited school or program of public health;

''(B) have demonstrated expertise in public health and have a graduate degree in a course of study or program (approved by the Secretary) from—

''(i) an accredited school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

''(ii) another accredited school or program approved by the Secretary; or

''(C) be enrolled as a full-time or part-time student in the final year of a course of study or program (approved by the Secretary) offered by a school or program described in subparagraph (A) or (B), leading to a graduate degree;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

''(3) if applicable, complete a residency or internship; and

''(4) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional for the period of obligated service described in subsection (c)(2).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(4) shall contain—

''(1) an agreement by the Secretary to repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant public health workforce educational degree in accordance with the terms of the contract;

''(2) an agreement by the individual to serve full-time as a public health professional for a period of time equal to 2 years or such longer period as the individual may agree to; and

''(3) in the case of an individual described in subsection (b)(1)(C) who is in the final year of study and who has accepted employment as a public health professional, in accordance with section 340L(c), an agreement on the part of the individual to complete the education or training, maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training), and serve the period of obligated service described in paragraph (2).

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for reasonable educational expenses, including tuition, fees, books, equipment, and laboratory expenses, incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—

''(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (c), the Secretary may pay up to $35,000 (plus, beginning with fiscal year 2012, an amount determined by

the Secretary on an annual basis to reflect inflation) on behalf of the individual for loans described in paragraph (1).

''(B) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(e) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the loan repayment program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.''.

SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.

Section 765 (42 U.S.C. 295) is amended to read as follows:

''SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall establish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

''(b) GRANTS AND CONTRACTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in, an accredited professional training program in the field of public health (including such a program in nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine) for members of the public health workforce, including midcareer professionals;

''(2) to provide financial assistance in the form of traineeships and fellowships to students who are participants in any such program and who plan to specialize or work in the field of public health;

''(3) to plan, develop, operate, or participate in a program for the training of public health professionals who plan to teach in any program described in paragraph (1); and

''(4) to provide financial assistance in the form of traineeships and fellowships to public health professionals who are participants in any program described in paragraph (1) and who plan to teach in the field of public health, including nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under this section, an entity shall be—

''(1) an accredited health professions school, including an accredited school or program of public health; nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine;

''(2) a State, local, or tribal health department;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of public health professionals who serve in underserved communities.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among public health professionals).

''(3) Training individuals in public health specialties experiencing a significant shortage of public health professionals (as determined by the Secretary).

''(4) Training a high or significantly improved percentage of public health professionals serving in the Federal Government or a State, local, or tribal government.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.

Section 766 (42 U.S.C. 295a) is amended—

(1) in subsection (b)(1), by striking ''in furtherance of the goals established by the Secretary for the year 2000'' and inserting ''in furtherance of the goals established by the Secretary in the national prevention and wellness strategy under section 3121''; and

(2) by adding at the end the following:

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

Section 768 (42 U.S.C. 295c) is amended to read as follows:

''SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private nonprofit hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added by section 2216 of this Act, is amended by adding at the end the following:

''(b) PUBLIC HEALTH WORKFORCE.—For the purpose of carrying out subpart XII of part D of title III and sections 765, 766, and 768, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $51,000,000 for fiscal year 2011.

''(2) $54,000,000 for fiscal year 2012.

''(3) $57,000,000 for fiscal year 2013.

''(4) $59,000,000 for fiscal year 2014.

''(5) $62,000,000 for fiscal year 2015.''.

(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subsection (a) of section 770 (42 U.S.C. 295e) is amended by striking ''2002'' and inserting ''2015''.

Subtitle D—Adapting Workforce to Evolving Health System Needs

PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

SEC. 2241. SCHOLARSHIPS FOR DISADVANTAGED STUDENTS, LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS, AND EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS.

Paragraph (1) of section 738(a) (42 U.S.C. 293b(a)) is amended by striking ''not more than $20,000'' and all that follows through the end of the paragraph and inserting: ''not more than $35,000 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) of the principal and interest of the educational loans of such individuals.''.

SEC. 2242. NURSING WORKFORCE DIVERSITY GRANTS.

Subsection (b) of section 821 (42 U.S.C. 296m) is amended—

(1) in the heading, by striking ''GUIDANCE'' and inserting ''CONSULTATION''; and

(2) by striking ''shall take into consideration'' and all that follows through ''consult with nursing associations'' and inserting ''shall, as appropriate, consult with nursing associations''.

SEC. 2243. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

(a) IN GENERAL.—Title VII (42 U.S.C. 292 et seq.) is amended by inserting after section 739 the following:

''SEC. 739A. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

''The Secretary shall, to the extent practicable, coordinate the activities carried out under this part and section 821 in order to enhance the effectiveness of such activities and avoid duplication of effort.''.

(b) REPORT.—Section 736 (42 U.S.C. 293) is amended—

(1) by redesignating subsection (h) as subsection (i); and

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

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the activities carried out under this section.''.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS.

Section 741 (42 U.S.C. 293e) is amended—

(1) in the section heading, by striking ''**GRANTS FOR HEALTH PROFESSIONS EDUCATION**'' and inserting ''**CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS**'';

(2) by redesignating subsection (b) as subsection (h); and

(3) by striking subsection (a) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a cultural and linguistic competency training program for health professionals, including nurse professionals, consisting of awarding grants and contracts under subsection (b).

''(b) CULTURAL AND LINGUISTIC COMPETENCY TRAINING.—The Secretary shall award grants

to, or enter into contracts with, eligible entities—

''(1) to test, develop, and evaluate models of cultural and linguistic competency training (including continuing education) for health professionals; and

''(2) to implement cultural and linguistic competency training programs for health professionals developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Addressing, or partnering with an entity with experience addressing, the cultural and linguistic competency needs of the population to be served through the grant or contract.

''(2) Addressing health disparities.

''(3) Placing health professionals in regions experiencing significant changes in the cultural and linguistic demographics of populations, including communities along the United States-Mexico border.

''(4) Carrying out activities described in subsection (b) with respect to more than one health profession discipline, specialty, or subspecialty.

''(e) CONSULTATION.—The Secretary shall carry out this section in consultation with the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health and the National Center on Minority Health and Health Disparities.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given to the term in section 3171.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2252. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.

Part D of title VII (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

''SEC. 759. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.

''(a) PROGRAM.—The Secretary shall establish an innovations in interdisciplinary care training program consisting of awarding grants and contracts under subsection (b).

''(b) TRAINING PROGRAMS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to test, develop, and evaluate health professional training programs (including continuing education) designed to promote—

''(A) the delivery of health services through interdisciplinary and team-based models, which may include patient-centered medical home models, medication therapy management models, and models integrating physical, mental, or oral health services; and

''(B) coordination of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient's home; and

''(2) to implement such training programs developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity (including an area health education center or a geriatric education center); or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

''(2) Broad interdisciplinary team-based collaborations.

''(3) Addressing health disparities.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITIONS.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'interdisciplinary' means collaboration across health professions and specialties, which may include public health, nursing, allied health, dietetics or nutrition, and appropriate health specialties.''.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

Subpart 1 of part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

''SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

''(a) ADVISORY COMMITTEE.—The Secretary, acting through the Assistant Secretary for Health, shall establish a permanent advisory committee to be known as the Advisory Committee on Health Workforce Evaluation and Assessment (referred to in this section as the 'Advisory Committee') to develop and implement an integrated, coordinated, and strategic national health workforce policy reflective of current and evolving health workforce needs.

''(b) RESPONSIBILITIES.—The Advisory Committee shall—

''(1) not later than 1 year after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) classifications of the health workforce to ensure consistency of data collection on the health workforce; and

''(B) based on such classifications, standardized methodologies and procedures to enumerate the health workforce;

''(2) not later than 2 years after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) the supply, diversity, and geographic distribution of the health workforce;

''(B) the retention and expansion of the health workforce (on a short- and long-term basis) to ensure quality and adequacy of such workforce; and

''(C) policies to carry out the recommendations made pursuant to subparagraphs (A) and (B); and

''(3) not later than 4 years after the date of the establishment of the Advisory Committee, and every 2 years thereafter, submit updated recommendations to the Secretary under paragraphs (1) and (2).

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Advisory Committee, including coordinating and supporting the dissemination of the recommendations of the Advisory Committee.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Secretary shall appoint 15 members to serve on the Advisory Committee.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Advisory Committee for a term of 3 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 6 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to the Advisory Committee under paragraph (1)—

''(i) 5 shall be appointed for a term of 1 year;

''(ii) 5 shall be appointed for a term of 2 years; and

''(iii) 5 shall be appointed for a term of 3 years.

''(3) QUALIFICATIONS.—Members of the Advisory Committee shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Conducting and interpreting health workforce market analysis, including health care labor workforce analysis.

''(B) Conducting and interpreting health finance and economics research.

''(C) Delivering and administering health care services.

''(D) Delivering and administering health workforce education and training.

''(4) REPRESENTATION.—In appointing members of the Advisory Committee, the Secretary shall—

''(A) include no less than one representative of each of—

''(i) health professionals within the health workforce;

''(ii) health care patients and consumers;

''(iii) employers;

''(iv) labor unions; and

''(v) third-party health payors; and

''(B) ensure that—

''(i) all areas of expertise described in paragraph (3) are represented;

''(ii) the members of the Advisory Committee include members who, collectively, have significant experience working with—

''(I) populations in urban and federally designated rural and nonmetropolitan areas; and

''(II) populations who are underrepresented in the health professions, including underrepresented minority groups; and

''(iii) individuals who are directly involved in health professions education or practice do not constitute a majority of the members of the Advisory Committee.

''(5) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Advisory Committee shall not be considered employees of the Federal Government by reason of service on the Advisory Committee, except members of the Advisory Committee shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(6) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Advisory Committee shall not receive any pay for service on the Committee, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(e) CONSULTATION.—In carrying out this section, the Secretary shall consult with the Secretary of Education and the Secretary of Labor.

''(f) COLLABORATION.—The Advisory Committee shall collaborate with the advisory bodies at the Health Resources and Services Administration, the National Advisory Council (as authorized in section 337), the Advisory Committee on Training in Primary Care Medicine and Dentistry (as authorized in section 749A), the Advisory Committee on

Interdisciplinary, Community-Based Linkages (as authorized in section 756), the Advisory Council on Graduate Medical Education (as authorized in section 762), and the National Advisory Council on Nurse Education and Practice (as authorized in section 851).

''(g) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the activities of the Advisory Committee.

''(i) DEFINITION.—In this section, the term 'health workforce' includes all health care providers with direct patient care and support responsibilities, including physicians, nurses, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)(2)), allied health professionals, mental and behavioral health professionals (as defined in section 775(f)(2)), and public health professionals (including veterinarians engaged in public health practice).''.

PART 4—HEALTH WORKFORCE ASSESSMENT

SEC. 2271. HEALTH WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 (42 U.S.C. 294n) is amended—

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

(2) by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall, based upon the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b)—

''(1) collect data on the health workforce (as defined in section 764(i)), disaggregated by field, discipline, and specialty, with respect to—

''(A) the supply (including retention) of health professionals relative to the demand for such professionals;

''(B) the diversity of health professionals (including with respect to race, ethnic background, and sex); and

''(C) the geographic distribution of health professionals; and

''(2) collect such data on individuals participating in the programs authorized by subtitles A, B, and C and part 1 of subtitle D of title II of division C of the Affordable Health Care for America Act.

''(b) GRANTS AND CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary may award grants to, or enter into contracts with, eligible entities to carry out subsection (a).

''(2) ELIGIBILITY.—To be eligible for a grant or contract under this subsection, an entity shall be—

''(A) an accredited health professions school or program;

''(B) an academic health center;

''(C) a State, local, or tribal government;

''(D) a public or private entity; or

''(E) a consortium of 2 or more entities described in subparagraphs (A) through (D).

''(c) COLLABORATION AND DATA SHARING.—The Secretary shall collaborate with Federal departments and agencies, health professions organizations (including health professions education organizations), and professional medical societies for the purpose of carrying out subsection (a).

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the data collected under subsection (a).''.

(b) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b) of the Public Health Service Act, as added by section 2261, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with such Advisory Committee, may make a judgment about the classifications, methodologies, and procedures to be used for collection of data under section 761(a) of the Public Health Service Act, as amended by this section.

PART 5—AUTHORIZATION OF APPROPRIATIONS

SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added and amended, is further amended by adding at the end the following:

''(c) HEALTH PROFESSIONS TRAINING FOR DIVERSITY.—For the purpose of carrying out sections 736, 737, 738, 739, and 739A, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $90,000,000 for fiscal year 2011.

''(2) $97,000,000 for fiscal year 2012.

''(3) $100,000,000 for fiscal year 2013.

''(4) $104,000,000 for fiscal year 2014.

''(5) $110,000,000 for fiscal year 2015.

''(d) INTERDISCIPLINARY TRAINING PROGRAMS, ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT, AND HEALTH WORKFORCE ASSESSMENT.—For the purpose of carrying out sections 741, 759, 761, and 764, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $87,000,000 for fiscal year 2011.

''(2) $97,000,000 for fiscal year 2012.

''(3) $103,000,000 for fiscal year 2013.

''(4) $105,000,000 for fiscal year 2014.

''(5) $113,000,000 for fiscal year 2015.''.

(b) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(1) SECTION 736.—Paragraph (1) of section 736(i) (42 U.S.C. 293(h)), as redesignated, is amended by striking ''2002'' and inserting ''2015''.

(2) SECTIONS 737, 738, AND 739.—Subsections (a), (b), and (c) of section 740 are amended by striking ''2002'' each place it appears and inserting ''2015''.

(3) SECTION 741.—Subsection (h), as so redesignated, of section 741 is amended—

(A) by striking ''and'' after ''fiscal year 2003,''; and

(B) by inserting '', and such sums as may be necessary for each subsequent fiscal year through the end of fiscal year 2015'' before the period at the end.

(4) SECTION 761.—Subsection (e)(1), as so redesignated, of section 761 is amended by striking ''2002'' and inserting ''2015''.

TITLE III—PREVENTION AND WELLNESS

SEC. 2301. PREVENTION AND WELLNESS.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title XXX the following:

''TITLE XXXI—PREVENTION AND WELLNESS

''Subtitle A—Prevention and Wellness Trust

''SEC. 3111. PREVENTION AND WELLNESS TRUST.

(a) ''DEPOSITS INTO TRUST.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust, out of any monies in the Public Health Investment Fund—

''(1) for fiscal year 2011, $2,400,000,000;

''(2) for fiscal year 2012, $2,845,000,000;

''(3) for fiscal year 2013, $3,100,000,000;

''(4) for fiscal year 2014, $3,455,000,000; and

''(5) for fiscal year 2015, $3,600,000,000.

''(b) AVAILABILITY OF FUNDS.—Amounts in the Prevention and Wellness Trust shall be available, as provided in advance in appropriation Acts, for carrying out this title.

''(c) ALLOCATION.—Of the amounts authorized to be appropriated in subsection (a), there are authorized to be appropriated—

''(1) for carrying out subtitle C (Prevention Task Forces), $30,000,000 for each of fiscal years 2011 through 2015;

''(2) for carrying out subtitle D (Prevention and Wellness Research)—

''(A) for fiscal year 2011, $155,000,000;

''(B) for fiscal year 2012, $205,000,000;

''(C) for fiscal year 2013, $255,000,000;

''(D) for fiscal year 2014, $305,000,000; and

''(E) for fiscal year 2015, $355,000,000;

''(3) for carrying out subtitle E (Delivery of Community Preventive and Wellness Services)—

''(A) for fiscal year 2011, $1,065,000,000;

''(B) for fiscal year 2012, $1,260,000,000;

''(C) for fiscal year 2013, $1,365,000,000;

''(D) for fiscal year 2014, $1,570,000,000; and

''(E) for fiscal year 2015, $1,600,000,000;

''(4) for carrying out section 3161 (Core Public Health Infrastructure for State, Local, and Tribal Health Departments)—

''(A) for fiscal year 2011, $800,000,000;

''(B) for fiscal year 2012, $1,000,000,000;

''(C) for fiscal year 2013, $1,100,000,000;

''(D) for fiscal year 2014, $1,200,000,000; and

''(E) for fiscal year 2015, $1,265,000,000; and

''(5) for carrying out section 3162 (Core Public Health Infrastructure and Activities for CDC), $350,000,000 for each of fiscal years 2011 through 2015.

''Subtitle B—National Prevention and Wellness Strategy

''SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRATEGY.

''(a) IN GENERAL.—The Secretary shall submit to the Congress within one year after the date of the enactment of this section, and at least every 2 years thereafter, a national strategy that is designed to improve the Nation's health through evidence-based clinical and community prevention and wellness activities (in this section referred to as 'prevention and wellness activities'), including core public health infrastructure improvement activities.

''(b) CONTENTS.—The strategy under subsection (a) shall include each of the following:

''(1) Identification of specific national goals and objectives in prevention and wellness activities that take into account appropriate public health measures and standards, including departmental measures and standards (including Healthy People and National Public Health Performance Standards).

''(2) Establishment of national priorities for prevention and wellness, taking into account unmet prevention and wellness needs.

''(3) Establishment of national priorities for research on prevention and wellness, taking into account unanswered research questions on prevention and wellness.

''(4) Identification of health disparities in prevention and wellness.

''(5) Review of prevention payment incentives, the prevention workforce, and prevention delivery system capacity.

''(6) A plan for addressing and implementing paragraphs (1) through (5).

''(c) CONSULTATION.—In developing or revising the strategy under subsection (a), the Secretary shall consult with the following:

''(1) The heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority

Health, the Office on Women's Health, and the Substance Abuse and Mental Health Services Administration.

''(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(3) As appropriate, nonprofit and for-profit entities.

''(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.

''(5) The Task Force on Community Preventive Services and the Task Force on Clinical Preventive Services.

''Subtitle C—Prevention Task Forces

''SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify clinical preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the Task Force's standards for a grade of A or B;

''(6) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

''(7) consult with the Task Force on Community Preventive Services established under section 3132; and

''(8) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this title—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Health promotion and disease prevention.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Application of systematic evidence reviews to clinical decisionmaking or health policy.

''(D) Clinical primary care in child and adolescent health.

''(E) Clinical primary care in adult health, including women's health.

''(F) Clinical primary care in geriatrics.

''(G) Clinical counseling and behavioral services for primary care patients.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary shall ensure that—

''(A) all areas of expertise described in paragraph (3) are represented; and

''(B) the members of the Task Force include individuals with expertise in health disparities.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

''(2) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of clinical preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Center on Minority Health and Health Disparities, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(6), the clinical prevention stakeholders board shall—

''(A) recommend clinical preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Agency for Healthcare Research and Quality.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the clinical prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task Force or the clinical prevention stakeholders board, except members of the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

''SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a permanent task force to be known as the Task Force on Community Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify community preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in community preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) pursuant to section 3143(d), determine whether subsidies and rewards are effective;

''(6) as appropriate, consult with the community prevention stakeholders board in accordance with subsection (f);

''(7) consult with the Task Force on Clinical Preventive Services established under section 3131; and

''(8) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this section—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Public health.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Disciplines relevant to community preventive services, including health promotion; disease prevention; chronic disease; worksite health; school-site health; qualitative and quantitative analysis; and health economics, policy, law, and statistics.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary—

''(A) shall ensure that all areas of expertise described in paragraph (3) are represented;

''(B) shall ensure that such members include sufficient representatives of each of—

''(i) State health officers;

''(ii) local health officers;

''(iii) health care practitioners; and

''(iv) public health practitioners; and

''(C) shall appoint individuals who have expertise in health disparities.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) COMMUNITY PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a community prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in community preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of community preventive services.

''(2) MEMBERSHIP.—The members of the community prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of community preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Center on Minority Health and Health Disparities, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(6), the community prevention stakeholders board shall—

''(A) recommend community preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Centers for Disease Control and Prevention.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the community prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task Force or the community prevention stakeholders board, except members of the Task Force or the community prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the community prevention stakeholders board shall not receive any pay for service on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

"Subtitle D—Prevention and Wellness Research

"SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIVITY COORDINATION.

''In conducting or supporting research on prevention and wellness, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and the heads of other agencies within the Department of Health and Human Services conducting or supporting such research, shall take into consideration the national strategy under section 3121 and the recommendations of the Task Force on Clinical Preventive Services under section 3131 and the Task Force on Community Preventive Services under section 3132.

"SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RESEARCH GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct, or award grants to eligible entities to conduct, research in priority areas identified by the Secretary in the national strategy under section 3121 or by the Task Force on Community Preventive Services as required by section 3132.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

''(1) a State, local, or tribal department of health;

''(2) a public or private nonprofit entity; or

''(3) a consortium of 2 or more entities described in paragraphs (1) and (2).

''(c) REPORT.—The Secretary shall submit to the Congress an annual report on the program of research under this section.

"SEC. 3143. RESEARCH ON SUBSIDIES AND REWARDS TO ENCOURAGE WELLNESS AND HEALTHY BEHAVIORS.

''(a) RESEARCH AND DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—The Secretary shall conduct, or award grants to public or nonprofit private entities to conduct, research and demonstration projects on the use of financial and in-kind subsidies and rewards to encourage individuals and communities to promote wellness, adopt healthy behaviors, and use evidence-based preventive health services.

''(2) FOCUS.—Research and demonstration projects under paragraph (1) shall focus on—

''(A) tobacco use, obesity, and other prevention and wellness priorities identified by the Secretary in the national strategy under section 3121;

''(B) the initiation, maintenance, and long-term sustainability of wellness promotion; adoption of healthy behaviors; and use of evidence-based preventive health services; and

''(C) populations at high risk of preventable diseases and conditions.

''(b) FINDINGS; REPORT.—

''(1) SUBMISSION OF FINDINGS.—The Secretary shall submit the findings of research and demonstration projects under subsection (a) to—

''(A) the Task Force on Clinical Preventive Services established under section 3131 or the Task Force on Community Preventive Services established under section 3132, as appropriate; and

''(B) the Health Benefits Advisory Committee established by section 223 of the Affordable Health Care for America Act.

''(2) REPORT TO CONGRESS.—Not later than 18 months after the initiation of research and demonstration projects under subsection (a), the Secretary shall submit a report to the Congress on the progress of such research and projects, including any preliminary findings.

''(c) INCLUSION IN ESSENTIAL BENEFITS PACKAGE.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3131, the Task Force on Clinical Preventive Services determines that a subsidy or reward meets the Task Force's standards for a grade A or B, the Secretary shall ensure that the subsidy or reward is included in the essential benefits package under section 222.

''(d) INCLUSION AS ALLOWABLE USE OF COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3132, the Task Force on Community Preventive Services determines that a subsidy or reward is effective, the Secretary shall ensure that the subsidy or reward becomes an allowable use of grant funds under section 3151.

''(e) NONDISCRIMINATION; NO TIE TO PREMIUM OR COST SHARING.—In carrying out this section, the Secretary shall ensure that any subsidy or reward—

''(1) does not have a discriminatory effect on the basis of any personal characteristic extraneous to the provision of high-quality health care or related services; and

''(2) is not tied to the premium or cost sharing of an individual under any qualified health benefits plan (as defined in section 100(c)).

"Subtitle E—Delivery of Community Prevention and Wellness Services

"SEC. 3151. COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program for the delivery of community prevention and wellness services consisting of awarding grants to eligible entities—

''(1) to provide evidence-based, community prevention and wellness services in priority areas identified by the Secretary in the national strategy under section 3121; or

''(2) to plan such services.

''(b) ELIGIBILITY.—

''(1) DEFINITION.—To be eligible for a grant under this section, an entity shall be—

''(A) a State, local, or tribal department of health;

''(B) a public or private entity; or

''(C) a consortium that—

''(i) consists of 2 or more entities described in subparagraph (A) or (B); and

''(ii) may be a community partnership representing a Health Empowerment Zone.

''(2) HEALTH EMPOWERMENT ZONE.—In this subsection, the term 'Health Empowerment Zone' means an area—

''(A) in which multiple community prevention and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121; and

''(B) which is represented by a community partnership that demonstrates community support and coordination with State, local, or tribal health departments and includes—

''(i) a broad cross section of stakeholders;

''(ii) residents of the community; and

''(iii) representatives of entities that have a history of working within and serving the community.

''(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to entities that—

''(1) will address one or more goals or objectives identified by the Secretary in the national strategy under section 3121;

''(2) will address significant health disparities, including those identified by the Secretary in the national strategy under section 3121;

''(3) will address unmet community prevention and wellness needs and avoid duplication of effort;

''(4) have been demonstrated to be effective in communities comparable to the proposed target community;

''(5) will contribute to the evidence base for community prevention and wellness services;

''(6) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

''(7) demonstrate coordination or collaboration across governmental and nongovernmental partners.

''(d) HEALTH DISPARITIES.—Of the funds awarded under this section for a fiscal year, the Secretary shall award not less than 50 percent for planning or implementing community prevention and wellness services whose primary purpose is to achieve a measurable reduction in one or more health disparities, including those identified by the Secretary in the national strategy under section 3121.

''(e) EMPHASIS ON RECOMMENDED SERVICES.—For fiscal year 2014 and subsequent fiscal years, the Secretary shall award grants under this section only for planning or implementing services recommended by the Task Force on Community Preventive Services under section 3132 or deemed effective based on a review of comparable rigor (as determined by the Director of the Centers for Disease Control and Prevention).

''(f) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(1) to build or acquire real property or for construction; or

''(2) for services or planning to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants awarded under this section.

''(h) DEFINITIONS.—In this section, the term 'evidence-based' means that methodologically sound research has demonstrated a beneficial health effect, in the judgment of the Director of the Centers for Disease Control and Prevention.

''Subtitle F—Core Public Health Infrastructure

''SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.

''(a) PROGRAM.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a core public health infrastructure program consisting of awarding grants under subsection (b).

''(b) GRANTS.—

''(1) AWARD.—For the purpose of addressing core public health infrastructure needs, the Secretary—

''(A) shall award a grant to each State health department; and

''(B) may award grants on a competitive basis to State, local, or tribal health departments.

''(2) ALLOCATION.—Of the total amount of funds awarded as grants under this subsection for a fiscal year—

''(A) not less than 50 percent shall be for grants to State health departments under paragraph (1)(A); and

''(B) not less than 30 percent shall be for grants to State, local, or tribal health departments under paragraph (1)(B).

''(c) USE OF FUNDS.—The Secretary may award a grant to an entity under subsection (b)(1) only if the entity agrees to use the grant to address core public health infrastructure needs, including those identified in the accreditation process under subsection (g).

''(d) FORMULA GRANTS TO STATE HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(A), the Secretary shall award funds to each State health department in accordance with—

''(1) a formula based on population size; burden of preventable disease and disability; and core public health infrastructure gaps, including those identified in the accreditation process under subsection (g); and

''(2) application requirements established by the Secretary, including a requirement that the State submit a plan that demonstrates to the satisfaction of the Secretary that the State's health department will—

''(A) address its highest priority core public health infrastructure needs; and

''(B) as appropriate, allocate funds to local health departments within the State.

''(e) COMPETITIVE GRANTS TO STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(B), the Secretary shall give priority to applicants demonstrating core public health infrastructure needs identified in the accreditation process under subsection (g).

''(f) MAINTENANCE OF EFFORT.—The Secretary may award a grant to an entity under subsection (b) only if the entity demonstrates to the satisfaction of the Secretary that—

''(1) funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the purpose of addressing core public health infrastructure needs; and

''(2) with respect to activities for which the grant is awarded, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant.

''(g) ESTABLISHMENT OF A PUBLIC HEALTH ACCREDITATION PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) develop, and periodically review and update, standards for voluntary accreditation of State, local, or tribal health departments and public health laboratories for the purpose of advancing the quality and performance of such departments and laboratories; and

''(B) implement a program to accredit such health departments and laboratories in accordance with such standards.

''(2) COOPERATIVE AGREEMENT.—The Secretary may enter into a cooperative agreement with a private nonprofit entity to carry out paragraph (1).

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on progress being made to accredit entities under subsection (g), including—

''(1) a strategy, including goals and objectives, for accrediting entities under subsection (g) and achieving the purpose described in subsection (g)(1); and

''(2) identification of gaps in research related to core public health infrastructure and recommendations of priority areas for such research.

''SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND ACTIVITIES FOR CDC.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and improve the core public health infrastructure and activities of the Centers for Disease Control and Prevention to address unmet and emerging public health needs.

''(b) REPORT.—The Secretary shall submit to the Congress an annual report on the activities funded through this section.

''Subtitle G—General Provisions

''SEC. 3171. DEFINITIONS.

''In this title:

''(1) The term 'core public health infrastructure' includes workforce capacity and competency; laboratory systems; health information, health information systems, and health information analysis; communications; financing; other relevant components of organizational capacity; and other related activities.

''(2) The terms 'Department' and 'departmental' refer to the Department of Health and Human Services.

''(3) The term 'health disparities' includes health and health care disparities and means population-specific differences in the presence of disease, health outcomes, or access to health care. For purposes of the preceding sentence, a population may be delineated by race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, or rural, urban, or other geographic setting, and any other population or subpopulation determined by the Secretary to experience significant gaps in disease, health outcomes, or access to health care.

''(4) The term 'tribal' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.''.

(b) TRANSITION PROVISIONS APPLICABLE TO TASK FORCES.—

(1) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Preventive Services Task Force convened under section 915(a) of the Public Health Service Act and the Task Force on Community Preventive Services (as such section and Task Forces were in existence on the day before the date of the enactment of this Act) shall be transferred to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(2) RECOMMENDATIONS.—All recommendations of the Preventive Services Task Force

and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(3) MEMBERS ALREADY SERVING.—

(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select those individuals already serving on the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(B) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall not include any period of service by the member on the Preventive Services Task Force or the Task Force on Community Preventive Services, respectively, as in existence on the day before the date of the enactment of this Act.

(c) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the national strategy under section 3121 of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services, acting through the relevant agency head, may make a judgment about how the strategy will address an issue and rely on such judgment in carrying out any provision of subtitle C, D, E, or F of title XXXI of such Act, as added by subsection (a), that requires the Secretary—

(1) to take into consideration such strategy;

(2) to conduct or support research or provide services in priority areas identified in such strategy; or

(3) to take any other action in reliance on such strategy.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (61) of section 3(b) of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended by striking ''United States Preventive Services Task Force'' and inserting ''Task Force on Clinical Preventive Services''.

(2) Section 126 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

(3) Paragraph (7) of section 317D(a) of the Public Health Service Act (42 U.S.C. 247b–5(a)) is amended by striking ''United States Preventive Services Task Force'' and inserting ''Task Force on Clinical Preventive Services''.

(4) Section 915 of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a).

(5) Subsections (s)(2)(AA)(iii)(II), (xx)(1), and (ddd)(1)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x) are amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

TITLE IV—QUALITY AND SURVEILLANCE

SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE.

(a) IN GENERAL.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as redesignated, by striking ''931'' and inserting ''941''; and

(4) by inserting after part C the following:

''PART D—IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE

''SEC. 931. CENTER FOR QUALITY IMPROVEMENT.

''(a) IN GENERAL.—There is established the Center for Quality Improvement (referred to in this part as the 'Center'), to be headed by the Director.

''(b) PRIORITIZATION.—

''(1) IN GENERAL.—The Director shall prioritize areas for the identification, development, evaluation, and implementation of best practices (including innovative methodologies and strategies) for quality improvement activities in the delivery of health care services (in this section referred to as 'best practices').

''(2) CONSIDERATIONS.—In prioritizing areas under paragraph (1), the Director shall consider—

''(A) the priorities established under section 1191 of the Social Security Act; and

''(B) the key health indicators identified by the Assistant Secretary for Health Information under section 1709.

''(3) LIMITATIONS.—In conducting its duties under this subsection, the Center for Quality Improvement shall not develop quality-adjusted life year measures or any other methodologies that can be used to deny benefits to a beneficiary against the beneficiary's wishes on the basis of the beneficiary's age, life expectancy, present or predicted disability, or expected quality of life.

''(c) OTHER RESPONSIBILITIES.—The Director, acting directly or by awarding a grant or contract to an eligible entity, shall—

''(1) identify existing best practices under subsection (e);

''(2) develop new best practices under subsection (f);

''(3) evaluate best practices under subsection (g);

''(4) implement best practices under subsection (h);

''(5) ensure that best practices are identified, developed, evaluated, and implemented under this section consistent with standards adopted by the Secretary under section 3004 for health information technology used in the collection and reporting of quality information (including for purposes of the demonstration of meaningful use of certified electronic health record (EHR) technology by physicians and hospitals under the Medicare program (under sections 1848(o)(2) and 1886(n)(3), respectively, of the Social Security Act)); and

''(6) provide for dissemination of information and reporting under subsections (i) and (j).

''(d) ELIGIBILITY.—To be eligible for a grant or contract under subsection (c), an entity shall—

''(1) be a nonprofit entity;

''(2) agree to work with a variety of institutional health care providers, physicians, nurses, and other health care practitioners; and

''(3) if the entity is not the organization holding a contract under section 1153 of the Social Security Act for the area to be served, agree to cooperate with and avoid duplication of the activities of such organization.

''(e) IDENTIFYING EXISTING BEST PRACTICES.—The Director shall identify best practices that are—

''(1) currently utilized by health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) that deliver consistently high-quality, efficient health care services; and

''(2) easily adapted for use by other health care providers and for use across a variety of health care settings.

''(f) DEVELOPING NEW BEST PRACTICES.—The Director shall develop best practices that are—

''(1) based on a review of existing scientific evidence;

''(2) sufficiently detailed for implementation and incorporation into the workflow of health care providers; and

''(3) designed to be easily adapted for use by health care providers across a variety of health care settings.

''(g) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation—

''(1) shall include determinations of which best practices—

''(A) most reliably and effectively achieve significant progress in improving the quality of patient care; and

''(B) are easily adapted for use by health care providers across a variety of health care settings;

''(2) shall include regular review, updating, and improvement of such best practices; and

''(3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) and simulations of such best practices for determinations under paragraph (1).

''(h) IMPLEMENTATION OF BEST PRACTICES.—

''(1) IN GENERAL.—The Director shall enter into arrangements with entities in a State or region to implement best practices identified or developed under this section. Such implementation—

''(A) may include forming collaborative multi-institutional teams; and

''(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.

''(2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—

''(A) have the greatest impact on patient outcomes and satisfaction;

''(B) are the most easily adapted for use by health care providers across a variety of health care settings;

''(C) promote coordination of health care practitioners across the continuum of care; and

''(D) engage patients and their families in improving patient care and outcomes.

''(i) PUBLIC DISSEMINATION OF INFORMATION.—The Director shall provide for the public dissemination of information with respect to best practices and activities under this section. Such information shall be made available in appropriate formats and languages to reflect the varying needs of consumers and diverse levels of health literacy.

''(j) REPORT.—

''(1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

''(2) CONTENT.—Each report under paragraph (1) shall include—

''(A) information on activities conducted pursuant to grants and contracts awarded;

''(B) summary data on patient outcomes before, during, and after implementation of best practices; and

''(C) recommendations on the adaptability of best practices for use by health providers.''.

(b) INITIAL QUALITY IMPROVEMENT ACTIVITIES AND INITIATIVES TO BE IMPLEMENTED.—Until the Director of the Agency for Healthcare Research and Quality has established initial priorities under section 931(b) of the Public Health Service Act, as added by subsection (a), the Director shall, for purposes of such section, prioritize the following:

(1) HEALTH CARE-ASSOCIATED INFECTIONS.—Reducing health care-associated infections, including infections in nursing homes and outpatient settings.

(2) SURGERY.—Increasing hospital and outpatient perioperative patient safety, including reducing surgical-site infections and surgical errors (such as wrong-site surgery and retained foreign bodies).

(3) EMERGENCY ROOM.—Improving care in hospital emergency rooms, including through the use of principles of efficiency of design and delivery to improve patient flow.

(4) OBSTETRICS.—Improving the provision of obstetrical and neonatal care, including the identification of interventions that are effective in reducing the risk of preterm and premature labor and the implementation of best practices for labor and delivery care.

(5) PEDIATRICS.—Improving the provision of preventive and developmental child health services, including interventions that can reduce child health disparities (as defined in section 3171 of the Public Health Service Act, as added by section 2301) and reduce the risk of developing chronic health-threatening conditions that affect an individual's life course development.

(c) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall submit a report to the Congress on the impact of the nurse-to-patient ratio on the quality of care and patient outcomes, including recommendations for further integration into quality measurement and quality improvement activities.

SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

(a) ESTABLISHMENT.—Title XVII (42 U.S.C. 300u et seq.) is amended—

(1) by redesignating sections 1709 and 1710 as sections 1710 and 1711, respectively; and

(2) by inserting after section 1708 the following:

''SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

''(a) IN GENERAL.—There is established within the Department an Assistant Secretary for Health Information (in this section referred to as the 'Assistant Secretary'), to be appointed by the Secretary.

''(b) RESPONSIBILITIES.—The Assistant Secretary shall—

''(1) ensure the collection, collation, reporting, and publishing of information (including full and complete statistics) on key health indicators regarding the Nation's health and the performance of the Nation's health care;

''(2) facilitate and coordinate the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care (other than information described in paragraph (1));

''(3)(A) develop standards for the collection of data regarding the Nation's health and the performance of the Nation's health care; and

''(B) in carrying out subparagraph (A)—

''(i) ensure appropriate specificity and standardization for data collection at the national, regional, State, and local levels;

''(ii) include standards, as appropriate, for the collection of accurate data on health disparities;

''(iii) ensure, with respect to data on race and ethnicity, consistency with the 1997 Office of Management and Budget Standards for Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity (or any successor standards); and

''(iv) in consultation with the Director of the Office of Minority Health, and the Director of the Office of Civil Rights of the Department, develop standards for the collection of data on health and health care with respect to primary language;

''(4) provide support to Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary) for the collection and collation of information described in paragraphs (1) and (2);

''(5) ensure the sharing of information described in paragraphs (1) and (2) among the agencies of the Department;

''(6) facilitate the sharing of information described in paragraphs (1) and (2) by Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary);

''(7) identify gaps in information described in paragraphs (1) and (2) and the appropriate agency or entity to address such gaps;

''(8) facilitate and coordinate identification and monitoring of health disparities by the agencies of the Department to inform program and policy efforts to reduce such disparities, including facilitating and funding analyses conducted in cooperation with the Social Security Administration, the Bureau of the Census, and other appropriate agencies and entities;

''(9) consistent with privacy, proprietary, and other appropriate safeguards, facilitate public accessibility of datasets (such as de-identified Medicare datasets or publicly available data on key health indicators) by means of the Internet; and

''(10) award grants or contracts for the collection and collation of information described in paragraphs (1) and (2) (including through statewide surveys that provide standardized information).

''(c) KEY HEALTH INDICATORS.—

''(1) IN GENERAL.—In carrying out subsection (b)(1), the Assistant Secretary shall—

''(A) identify, and reassess at least once every 3 years, key health indicators described in such subsection;

''(B) publish statistics on such key health indicators for the public—

''(i) not less than annually; and

''(ii) on a supplemental basis whenever warranted by—

''(I) the rate of change for a key health indicator; or

''(II) the need to inform policy regarding the Nation's health and the performance of the Nation's health care; and

''(C) ensure consistency with the national strategy developed by the Secretary under section 3121 and consideration of the indicators specified in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(2) RELEASE OF KEY HEALTH INDICATORS.—The regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of key health indicators shall be the same as the regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of Principal Federal Economic Indicators (or equivalent statistical data) by the Bureau of Labor Statistics.

''(d) COORDINATION.—In carrying out this section, the Assistant Secretary shall coordinate with—

''(1) public and private entities that collect and disseminate information on health and health care, including foundations; and

''(2) the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology.

''(e) REQUEST FOR INFORMATION FROM DEPARTMENTS AND AGENCIES.—Consistent with applicable law, the Assistant Secretary may secure directly from any Federal department or agency information necessary to enable the Assistant Secretary to carry out this section.

''(f) REPORT.—

''(1) SUBMISSION.—The Assistant Secretary shall submit to the Secretary and the Congress an annual report containing—

''(A) a description of national, regional, or State changes in health or health care, as reflected by the key health indicators identified under subsection (c)(1);

''(B) a description of gaps in the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care;

''(C) recommendations for addressing such gaps and identification of the appropriate agency within the Department or other entity to address such gaps;

''(D) a description of analyses of health disparities, including the results of completed analyses, the status of ongoing longitudinal studies, and proposed or planned research; and

''(E) a plan for actions to be taken by the Assistant Secretary to address gaps described in subparagraph (B).

''(2) CONSIDERATION.—In preparing a report under paragraph (1), the Assistant Secretary shall take into consideration the findings and conclusions in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(g) PROPRIETARY AND PRIVACY PROTECTIONS.—Nothing in this section shall be construed to affect applicable proprietary or privacy protections.

''(h) CONSULTATION.—In carrying out this section, the Assistant Secretary shall consult with—

''(1) the heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Office on Women's Health; and

''(2) as appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(i) DEFINITION.—In this section:

''(1) The terms 'agency' and 'agencies' include an epidemiology center established under section 214 of the Indian Health Care Improvement Act.

''(2) The term 'Department' means the Department of Health and Human Services.

''(3) The term 'health disparities' has the meaning given to such term in section 3171.''.

(b) OTHER COORDINATION RESPONSIBILITIES.—Title III (42 U.S.C. 241 et seq.) is amended—

(1) in paragraphs (1) and (2) of section 304(c) (42 U.S.C. 242b(c)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''The Secretary'' each place it appears; and

(2) in section 306(j) (42 U.S.C. 242k(j)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''of this section, the Secretary''.

SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.

Section 799C, as added and amended, is further amended by adding at the end the following:

''(e) QUALITY AND SURVEILLANCE.—For the purpose of carrying out part D of title IX and

section 1709, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, $300,000,000 for each of fiscal years 2011 through 2015.''.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

SEC. 2501. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

''(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act).

''(O) An entity receiving funds under title V of the Social Security Act (relating to maternal and child health) for the provision of health services.

''(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.

''(Q) An entity receiving funds under subpart II of such part B (relating to the prevention and treatment of substance abuse) for the provision of treatment services for substance abuse.

''(R) An entity that is a Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act).

''(S) An entity that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(T) An entity that is classified as a rural referral center under section 1886(d)(5)(C) of the Social Security Act.''.

(b) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) by adding ''and'' at the end of clause (i);

(B) by striking ''; and'' at the end of clause (ii) and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following:

''(C) PROHIBITING USE OF GROUP PURCHASING ARRANGEMENTS.—A hospital described in subparagraph (L), (M), (N), (R), (S), or (T) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.''.

SEC. 2502. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Section 340B (42 U.S.C. 256b) is amended—

(1) by striking subsections (c) and (d); and

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

''(c) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The establishment of a process to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing, through an appropriate policy or regulatory issuance, standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Conducting periodic monitoring of sales transactions to covered entities.

''(IV) Inquiring into any discrepancies between ceiling prices and manufacturer pricing data that may be identified and taking, or requiring manufacturers to take, corrective action in response to such discrepancies, including the issuance of refunds pursuant to the procedures set forth in clause (ii).

''(ii) The establishment of procedures for the issuance of refunds to covered entities by manufacturers in the event that the Secretary finds there has been an overcharge, including the following:

''(I) Submission to the Secretary by manufacturers of an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time.

''(iii) Notwithstanding any other provision of law prohibiting the disclosure of ceiling prices or data used to calculate the ceiling price, the provision of access to covered entities and State Medicaid agencies through an Internet website of the Department of Health and Human Services or contractor to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in a manner that ensures protection of privileged pricing data from unauthorized disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates, discounts, or other price concessions provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such rebates, discounts, or other price concessions have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) In addition to authorities under section 1927(b)(3) of the Social Security Act, the Secretary may conduct audits of manufacturers and wholesalers to ensure the integrity of the program under this section, including audits on the market price of covered drugs.

''(vi) The establishment of a requirement that manufacturers and wholesalers use the identification system developed by the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(vii) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards and procedures established in regulations to be promulgated by the Secretary within one year of the date of the enactment of the Affordable Health Care for America Act; and

''(II) shall apply to any manufacturer with an agreement under this section and shall not exceed $100,000 for each instance where a manufacturer knowingly charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1) or that knowingly violates any other provision of this section, or withholds or provides false information to the Secretary or to covered entities under this section.

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to update at least annually the information on the Internet Web site of the Department of Health and Human Services relating to this section.

''(ii) The development of procedures for the Secretary to verify the accuracy of information regarding covered entities that is listed on the Web site described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards and procedures established in regulations promulgated by the Secretary;

''(II) shall not exceed $5,000 for each violation; and

''(III) shall apply to any covered entity that knowingly violates subparagraph (a)(5)(B) or knowingly violates any other provision of this section.

''(vi) The exclusion of a covered entity from participation in the program under this section, for a period of time to be determined by the Secretary, in cases in which the Secretary determines, in accordance with standards and procedures established in regulations, that—

''(I) a violation of a requirement of this section was repeated and knowing; and

''(II) imposition of a monetary penalty would be insufficient to reasonably ensure compliance.

''(vii) The referral of matters as appropriate to the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies.

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—From amounts appropriated under paragraph (4), the Secretary may establish and implement an administrative process for the resolution of the following:

''(A) Claims by covered entities that manufacturers have violated the terms of their

agreement with the Secretary under subsection (a)(1).

''(B) Claims by manufacturers that covered entities have violated subsection (a)(5)(A) or (a)(5)(B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2011 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(A) by adding at the end of paragraph (1) the following: ''Such agreement shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price. Such agreement shall require that, if the supply of a covered drug is insufficient to meet demand, then the manufacturer may utilize an allocation method that is reported in writing to the Secretary and does not discriminate on the basis of the price paid by covered entities or on any other basis related to an entity's participation in the program under this section. Notwithstanding any other provision of law, if the Secretary requests a manufacturer to enter into a new or amended agreement under this section that complies with current law and if the manufacturer opts not to sign the new or amended agreement, then any existing agreement between the manufacturer and the Secretary under this section is deemed to no longer meet the requirements of this section for purposes of this section and section 1927 of the Social Security Act.''; and

(B) by adding at the end the following paragraph:

''(11) QUARTERLY REPORTS.—An agreement described in paragraph (1) shall require that the manufacturer furnish the Secretary with reports on a quarterly basis that include the following information:

''(A) The price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price').

''(B) The component information used to calculate the ceiling price as determined necessary to administer the requirements of the program under this section.

''(C) Rebates, discounts, and other price concessions provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities.''.

(2) Section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)) is amended by striking subparagraph (D).

SEC. 2503. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall take effect on the date of the enactment of this Act, and sections 2501, 2502(a)(1), and 2502(b)(2) shall apply to drugs dispensed on or after such date.

(b) EFFECTIVENESS.—The amendments made by this subtitle shall be effective, and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), and of section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)), notwithstanding any other provision of law.

Subtitle B—Programs

PART 1—GRANTS FOR CLINICS AND CENTERS

SEC. 2511. SCHOOL-BASED HEALTH CLINICS.

(a) IN GENERAL.—Part Q of title III (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

''SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.

''(a) PROGRAM.—The Secretary shall establish a school-based health clinic program consisting of awarding grants to eligible entities to support the operation of school-based health clinics (referred to in this section as 'SBHCs').

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (l)(3)); and

''(2) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum—

''(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided in accordance with Federal, State, and local laws;

''(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support and access to services with backup health providers when the school or SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school; and

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(D) such other information as the Secretary may require.

''(c) USE OF FUNDS.—Funds awarded under a grant under this section—

''(1) may be used for—

''(A) providing training related to the provision of comprehensive primary health services and additional health services;

''(B) the management and operation of SBHC programs, including through subcontracts; and

''(C) the payment of salaries for health professionals and other appropriate SBHC personnel; and

''(2) may not be used to provide abortions.

''(d) CONSIDERATION OF NEED.—In determining the amount of a grant under this section, the Secretary shall take into consideration—

''(1) the financial need of the SBHC;

''(2) State, local, or other sources of funding provided to the SBHC; and

''(3) other factors as determined appropriate by the Secretary.

''(e) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to SBHCs that have a demonstrated record of service to at least one of the following:

''(1) A high percentage of medically underserved children and adolescents.

''(2) Communities or populations in which children and adolescents have difficulty accessing health and mental health services.

''(3) Communities with high percentages of children and adolescents who are uninsured, underinsured, or eligible for medical assistance under Federal or State health benefits programs (including titles XIX and XXI of the Social Security Act).

''(f) MATCHING REQUIREMENT.—The Secretary may award a grant to an SBHC under this section only if the SBHC agrees to provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in kind) to carry out the activities supported by the grant.

''(g) SUPPLEMENT, NOT SUPPLANT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the SBHC for operation of the SBHC (including each activity described in paragraph (1) or (2) of subsection (c)).

''(h) PAYOR OF LAST RESORT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(1) under any insurance policy;

''(2) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(3) by an entity which provides health services on a prepaid basis.

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

''(j) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by grant or contract) technical and other assistance to SBHCs to assist such SBHCs to meet the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the SBHCs of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the SBHCs.

''(k) EVALUATION; REPORT.—The Secretary shall—

''(1) develop and implement a plan for evaluating SBHCs and monitoring quality performances under the awards made under this section; and

''(2) submit to the Congress on an annual basis a report on the program under this section.

''(l) DEFINITIONS.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by SBHCs, which—

''(A) shall include—

''(i) comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions and referrals to, and followup for, specialty care; and

''(ii) mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

''(B) may include additional services, such as oral health, social, and age-appropriate health education services, including nutritional counseling.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated by the Secretary as an area with a shortage of personal health services and health infrastructure for such children and adolescents.

''(3) SCHOOL-BASED HEALTH CLINIC.—The term 'school-based health clinic' means a health clinic that—

''(A) is located in, or is adjacent to, a school facility of a local educational agency;

''(B) is organized through school, community, and health provider relationships;

''(C) is administered by a sponsoring facility;

''(D) provides comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with State and local laws and regulations, established standards, and community practice; and

''(E) does not perform abortion services.

''(4) SPONSORING FACILITY.—The term 'sponsoring facility' is—

''(A) a hospital;

''(B) a public health department;

''(C) a community health center;

''(D) a nonprofit health care entity whose mission is to provide access to comprehensive primary health care services;

''(E) a local educational agency; or

''(F) a program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act, a Native Hawaiian entity, or an urban Indian program under title V of the Indian Health Care Improvement Act.

''(m) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall begin awarding grants under section 399Z–1 of the Public Health Service Act, as added by subsection (a), not later than July 1, 2010, without regard to whether or not final regulations have been issued under section 399Z–1(i) of such Act.

(c) TERMINATION OF STUDY.—Section 2(b) of the Health Care Safety Net Act of 2008 (42 U.S.C. 254b note) is amended by striking paragraph (2) (relating to a school-based health center study).

SEC. 2512. NURSE-MANAGED HEALTH CENTERS.

Title III (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART S—NURSE-MANAGED HEALTH CENTERS

''SEC. 399FF. NURSE-MANAGED HEALTH CENTERS.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a nurse-managed health center program consisting of awarding grants to entities under subsection (b).

''(b) GRANT.—The Secretary shall award grants to entities—

''(1) to plan and develop a nurse-managed health center; or

''(2) to operate a nurse-managed health center.

''(c) USE OF FUNDS.—Amounts received as a grant under subsection (b) may be used for activities including the following:

''(1) Purchasing or leasing equipment.

''(2) Training and technical assistance related to the provision of comprehensive primary care services and wellness services.

''(3) Other activities for planning, developing, or operating, as applicable, a nurse-managed health center.

''(d) ASSURANCES APPLICABLE TO BOTH PLANNING AND OPERATION GRANTS.—

''(1) IN GENERAL.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the Secretary's satisfaction that—

''(A) nurses, in addition to managing the center, will be adequately represented as providers at the center; and

''(B) not later than 90 days after receiving the grant, the entity will establish a community advisory committee composed of individuals, a majority of whom are being served by the center, to provide input into the nurse-managed health center's operations.

''(2) MATCHING REQUIREMENT.—The Secretary may award a grant under this section to an entity only if the entity agrees to provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in kind) to carry out the activities supported by the grant.

''(3) PAYOR OF LAST RESORT.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that funds received through the grant will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(4) MAINTENANCE OF EFFORT.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that—

''(A) funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the activities to be funded through the grant; and

''(B) with respect to such activities, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the lesser of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant.

''(e) ADDITIONAL ASSURANCE FOR PLANNING GRANTS.—The Secretary may award a grant under subsection (b)(1) to an entity only if the entity agrees—

''(1) to assess the needs of the medically underserved populations proposed to be served by the nurse-managed health center; and

''(2) to design services and operations of the nurse-managed health center for such populations based on such assessment.

''(f) ADDITIONAL ASSURANCE FOR OPERATION GRANTS.—The Secretary may award a grant under subsection (b)(2) to an entity only if the entity assures that the nurse-managed health center will provide—

''(1) comprehensive primary care services, wellness services, and other health care services deemed appropriate by the Secretary;

''(2) care without respect to insurance status or income of the patient; and

''(3) direct access to client-centered services offered by advanced practice nurses, other nurses, physicians, physician assistants, or other qualified health professionals.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by grant or contract) technical and other assistance to nurse-managed health centers to assist such centers in meeting the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to nurse-managed health centers regarding the various resources available under this section and how those resources can best be used to meet the health needs of the communities served by nurse-managed health centers.

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(i) DEFINITIONS.—In this section:

''(1) COMPREHENSIVE PRIMARY CARE SERVICES.—The term 'comprehensive primary care services' has the meaning given to the term 'required primary health services' in section 330(b)(1).

''(2) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given to such term in section 330(b)(3).

''(3) NURSE-MANAGED HEALTH CENTER.—The term 'nurse-managed health center' has the meaning given to such term in section 801.

''(4) WELLNESS SERVICES.—The term 'wellness services' means any health-related service or intervention, not including primary care, which is designed to reduce identifiable health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic conditions by teaching more effective management techniques that focus on individual self-care and patient-driven decisionmaking.

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

SEC. 2513. FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.

Section 1913 (42 U.S.C. 300x–3) is amended—

(1) in subsection (a)(2)(A), by striking ''community mental health services'' and inserting ''behavioral health services (of the type offered by federally qualified behavioral health centers consistent with subsection (c)(3))'';

(2) in subsection (b)—

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

''(1) services under the plan will be provided only through appropriate, qualified community programs (which may include federally qualified behavioral health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs); and'';

and

(B) in paragraph (2), by striking ''community mental health centers'' and inserting ''federally qualified behavioral health centers''; and

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

''(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

''(1) IN GENERAL.—The Administrator shall certify, and recertify at least every 5 years, federally qualified behavioral health centers as meeting the criteria specified in this subsection.

''(2) REGULATIONS.—Not later than 18 months after the date of the enactment of the Affordable Health Care for America Act, the Administrator shall issue final regulations for certifying centers under paragraph (1).

''(3) CRITERIA.—The criteria referred to in subsection (b)(2) are that the center performs each of the following:

''(A) Provide services in locations that ensure services will be available and accessible promptly and in a manner which preserves human dignity and assures continuity of care.

''(B) Provide services in a mode of service delivery appropriate for the target population.

''(C) Provide individuals with a choice of service options where there is more than one efficacious treatment.

''(D) Employ a core staff of clinical staff that is multidisciplinary and culturally and linguistically competent.

''(E) Provide services, within the limits of the capacities of the center, to any individual residing or employed in the service area of the center.

''(F) Provide, directly or through contract, to the extent covered for adults in the State Medicaid plan and for children in accordance with section 1905(r) of the Social Security Act regarding early and periodic screening, diagnosis, and treatment, each of the following services:

''(i) Screening, assessment, and diagnosis, including risk assessment.

''(ii) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

''(iii) Outpatient clinic mental health services, including screening, assessment, diagnosis, psychotherapy, substance abuse counseling, medication management, and integrated treatment for mental illness and substance abuse which shall be evidence-based (including cognitive behavioral therapy, dialectical behavioral therapy, motivational interviewing, and other such therapies which are evidence-based).

''(iv) Outpatient clinic primary care services, including screening and monitoring of key health indicators and health risk (including screening for diabetes, hypertension, and cardiovascular disease and monitoring of weight, height, body mass index (BMI), blood pressure, blood glucose or HbA1C, and lipid profile).

''(v) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

''(vi) Targeted case management (services to assist individuals gaining access to needed medical, social, educational, and other services and applying for income security and other benefits to which they may be entitled).

''(vii) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutic foster care services, multisystemic therapy, and such other evidence-based practices as the Secretary may require.

''(viii) Peer support and counselor services and family supports.

''(G) Maintain linkages, and where possible enter into formal contracts with, inpatient psychiatric facilities and substance abuse detoxification and residential programs.

''(H) Make available to individuals served by the center, directly, through contract, or through linkages with other programs, each of the following:

''(i) Adult and youth peer support and counselor services.

''(ii) Family support services for families of children with serious mental disorders.

''(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, housing agencies and programs, employers, and other social services.

''(iv) Onsite or offsite access to primary care services.

''(v) Enabling services, including outreach, transportation, and translation.

''(vi) Health and wellness services, including services for tobacco cessation.''.

PART 2—OTHER GRANT PROGRAMS

SEC. 2521. COMPREHENSIVE PROGRAMS TO PROVIDE EDUCATION TO NURSES AND CREATE A PIPELINE TO NURSING.

(a) PURPOSES.—It is the purpose of this section to authorize grants to—

(1) address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses) for incumbent ancillary health care workers;

(2) increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and

(3) provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.

(b) GRANTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (referred to in this section as the ''Secretary'') shall establish a partnership grant program to award grants to eligible entities to carry out comprehensive programs to provide education to nurses and create a pipeline to nursing for incumbent ancillary health care workers who wish to advance their careers, and to otherwise carry out the purposes of this section.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

(1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer and that carries out activities using labor-management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)(6));

(2) an entity that operates a training program that is jointly administered by—

(A) one or more health care providers or facilities, or a trade association of health care providers; and

(B) one or more organizations which represent the interests of direct care health care workers or staff nurses and in which the direct care health care workers or staff nurses have direct input as to the leadership of the organization;

(3) a State training partnership program that consists of nonprofit organizations that include equal participation from industry, including public or private employers, and labor organizations including joint labor-management training programs, and which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing; or

(4) a school of nursing (as defined in section 801 of the Public Health Service Act (42 U.S.C. 296)).

(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible for a grant under this section, a health care employer described in subsection (c) shall demonstrate that it—

(1) has an established program within its facility to encourage the retention of existing nurses;

(2) provides wages and benefits to its nurses that are competitive for its market or that have been collectively bargained with a labor organization; and

(3) supports programs funded under this section through 1 or more of the following:

(A) The provision of paid leave time and continued health coverage to incumbent health care workers to allow their participation in nursing career ladder programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.

(B) Contributions to a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work full- or part-time in a faculty position.

(D) The provision of paid release time for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced nursing degrees, specialty training, or certification program.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(e) OTHER REQUIREMENTS.—

(1) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subparagraph (A) may be in cash or in kind (including paid release time), fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) REQUIRED COLLABORATION.—Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate's, bachelor's, or advanced nursing degree programs or specialty training or certification programs.

(f) USE OF FUNDS.—Amounts awarded to an entity under a grant under this section shall be used for the following:

(1) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English-as-a-second-language education, GED education, precollege counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preference for dedicated cohort classes in community colleges, universities, and accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs that assist newly graduated nurses in adjusting to working at the bedside to ensure their retention postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incumbent health care workers to participate in these programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and

completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate's, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that—

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually evaluate, and submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include—

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of nurse faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, and patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

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

SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.

Part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 3—Mental and Behavioral Health Training

"SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAM.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Administrator of the Substance Abuse and Mental Health Services Administration, shall establish an interdisciplinary mental and behavioral health training program consisting of awarding grants and contracts under subsection (b).

''(b) SUPPORT AND DEVELOPMENT OF MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in an accredited professional training program for mental and behavioral health professionals to promote—

''(A) interdisciplinary training; and

''(B) coordination of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient's home;

''(2) to provide financial assistance to mental and behavioral health professionals, who are participants in any such program, and who plan to work in the field of mental and behavioral health;

''(3) to plan, develop, operate, or participate in an accredited program for the training of mental and behavioral health professionals who plan to teach in the field of mental and behavioral health; and

''(4) to provide financial assistance in the form of traineeships and fellowships to mental and behavioral health professionals who are participants in any such program and who plan to teach in the field of mental and behavioral health.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school, including an accredited school or program of psychology, psychiatry, social work, marriage and family therapy, professional mental health or substance abuse counseling, or addiction medicine;

''(2) an accredited public or nonprofit private hospital;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

''(2) Supporting teaching programs that address the health care needs of vulnerable populations.

''(3) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among mental and behavioral health professionals).

''(4) Training individuals who serve geriatric populations with an emphasis on underserved elderly.

''(5) Training individuals who serve pediatric populations with an emphasis on underserved children.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(f) DEFINITION.—In this section:

''(1) The term 'interdisciplinary' means collaboration across health professions, specialties, and subspecialties, which may include public health, nursing, allied health, dietetics or nutrition, and appropriate health specialties.

''(2) The term 'mental and behavioral health professional' means an individual training or practicing—

''(A) in psychology; general, geriatric, child or adolescent psychiatry; social work; marriage and family therapy; professional mental health or substance abuse counseling; or addiction medicine; or

''(B) another mental and behavioral health specialty, as deemed appropriate by the Secretary.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2011 through 2015. Of the amounts appropriated to carry out this section for a fiscal year, not less than 15 percent shall be used for training programs in psychology.''.

SEC. 2523. REAUTHORIZATION OF TELEHEALTH AND TELEMEDICINE GRANT PROGRAMS.

(a) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I (42 U.S.C. 254c–14) is amended—

(1) in subsection (a)—

(A) by striking paragraph (3) (relating to frontier communities); and

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

''(3) HEALTH DISPARITIES.—The term 'health disparities' has the meaning given such term in section 3171.'';

(2) in subsection (d)(1)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(D) reduce health disparities.'';

(3) in subsection (f)(1)(B)(iii)—

(A) in subclause (VII), by inserting '', including skilled nursing facilities'' before the period at the end;

(B) in subclause (IX), by inserting '', including county mental health and public mental health facilities'' before the period at the end; and

(C) by adding at the end the following:

''(XIII) Renal dialysis facilities.'';

(4) by amending subsection (i) to read as follows:

''(i) PREFERENCES.—

''(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for projects involving telehealth networks, the Secretary shall give preference to eligible entities meeting at least one of the following:

''(A) NETWORK.—The eligible entity is a health care provider in, or proposing to form, a health care network that furnishes services in a medically underserved area or a health professional shortage area.

''(B) BROAD GEOGRAPHIC COVERAGE.—The eligible entity demonstrates broad geographic coverage in the rural or medically underserved areas of the State or States in which the entity is located.

''(C) HEALTH DISPARITIES.—The eligible entity demonstrates how the project to be funded through the grant will address health disparities.

''(D) LINKAGES.—The eligible entity agrees to use the grant to establish or develop plans for telehealth systems that will link rural hospitals and rural health care providers to other hospitals, health care providers, and patients.

''(E) EFFICIENCY.—The eligible entity agrees to use the grant to promote greater efficiency in the use of health care resources.

''(F) VIABILITY.—The eligible entity demonstrates the long-term viability of projects through—

''(i) availability of non-Federal funding sources; or

''(ii) institutional and community support for the telehealth network.

''(G) SERVICES.—The eligible entity provides a plan for coordinating system use by eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

''(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to eligible entities meeting at least one of the following:

''(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of a broad range of telehealth services to medically underserved areas or populations.

''(B) PROVISION OF TELEHEALTH TECHNICAL ASSISTANCE.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

''(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.'';

(5) in subsection (j)(2)(B), by striking ''such projects for fiscal year 2001'' and all that follows through the period and inserting ''such projects for fiscal year 2010.'';

(6) in subsection (k)(1)—

(A) in subparagraph (E)(i), by striking ''transmission of medical data'' and inserting ''transmission and electronic archival of medical data''; and

(B) by amending subparagraph (F) to read as follows:

''(F) developing projects to use telehealth technology to—

''(i) facilitate collaboration between health care providers;

''(ii) promote telenursing services; or

''(iii) promote patient understanding and adherence to national guidelines for chronic disease and self-management of such conditions;'';

(7) in subsection (q), by striking ''Not later than September 30, 2005'' and inserting ''Not later than 1 year after the date of the enactment of the Affordable Health Care for America Act, and annually thereafter'';

(8) by striking subsection (r);

(9) by redesignating subsection (s) as subsection (r); and

(10) in subsection (r) (as so redesignated)—

(A) in paragraph (1)—

(i) by striking ''and'' before ''such sums''; and

(ii) by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the semicolon; and

(B) in paragraph (2)—

(i) by striking ''and'' before ''such sums''; and

(ii) by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the period.

(b) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—Subsection (b) of section 330L (42 U.S.C. 254c–18) is amended by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the period at the end.

SEC. 2524. NO CHILD LEFT UNIMMUNIZED AGAINST INFLUENZA: DEMONSTRATION PROGRAM USING ELEMENTARY AND SECONDARY SCHOOLS AS INFLUENZA VACCINATION CENTERS.

(a) PURPOSE.—The Secretary of Health and Human Services in consultation with the Secretary of Education, shall award grants to eligible partnerships to carry out demonstration programs designed to test the feasibility of using the Nation's elementary schools and secondary schools as influenza vaccination centers.

(b) IN GENERAL.—The Secretary shall coordinate with the Secretary of Labor, the Secretary of Education, State Medicaid agencies, State insurance agencies, and private insurers to carry out a program consisting of awarding grants under subsection (c) to ensure that children have coverage for all reasonable and customary expenses related to influenza vaccinations, including the costs of purchasing and administering the vaccine incurred when influenza vaccine is administered outside of the physician's office in a school or other related setting.

(c) PROGRAM DESCRIPTION.—

(1) GRANTS.—From amounts appropriated pursuant to subsection (l), the Secretary shall award grants to eligible partnerships to be used to provide influenza vaccinations to children in elementary and secondary schools, in coordination with school nurses, school health care programs, community health care providers, State insurance agencies, or private insurers.

(2) ACIP RECOMMENDATIONS.—The program under this section shall be designed to administer vaccines consistent with the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) for the annual vaccination of all children 5 through 19 years of age.

(3) PARTICIPATION VOLUNTARY.—Participation by a school or an individual shall be voluntary.

(d) USE OF FUNDS.—Eligible partnerships receiving a grant under this section shall ensure the maximum number of children access influenza vaccinations as follows:

(1) COVERED CHILDREN.—To the extent to which payment of the costs of purchasing or administering the influenza vaccine for children is not covered through other federally funded programs or through private insurance, eligible partnerships receiving a grant shall use funds to purchase and administer influenza vaccinations.

(2) CHILDREN COVERED BY OTHER FEDERAL PROGRAMS.—For children who are eligible under other federally funded programs for payment of the costs of purchasing or administering the influenza vaccine, eligible partnerships receiving a grant shall not use funds provided under this section for such costs.

(3) CHILDREN COVERED BY PRIVATE HEALTH INSURANCE.—For children who have private insurance, eligible partnerships receiving a grant shall offer assistance in accessing coverage for vaccinations administered through the program under this section.

(e) PRIVACY.—The Secretary shall ensure that the program under this section adheres to confidentiality and privacy requirements of section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and section 444 of the General Education Provisions Act (20 U.S.C. 1232g; commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'').

(f) APPLICATION.—An eligible partnership desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(g) DURATION.—Eligible partnerships receiving a grant shall administer a demonstration program funded through this section over a period of 2 consecutive school years.

(h) CHOICE OF VACCINE.—The program under this section shall not restrict the discretion of a health care provider to administer any influenza vaccine approved by the Food and Drug Administration for use in pediatric populations.

(i) AWARDS.—The Secretary shall award—

(1) a minimum of 10 grants in 10 different States to eligible partnerships that each include one or more public schools serving primarily low-income students; and

(2) a minimum of 5 grants in 5 different States to eligible partnerships that each include one or more public schools located in a rural local educational agency.

(j) REPORT.—Not later than 90 days following the completion of the program under this section, the Secretary shall submit to the Committees on Education and Labor, Energy and Commerce, and Appropriations of the House of Representatives and to the Committees on Health, Education, Labor, and Pensions and Appropriations of the Senate a report on the results of the program. The report shall include—

(1) an assessment of the influenza vaccination rates of school-age children in localities where the program is implemented, compared to the national average influenza vaccination rates for school-aged children, including whether school-based vaccination assists in achieving the recommendations of the Advisory Committee on Immunization Practices;

(2) an assessment of the utility of employing elementary schools and secondary schools as a part of a multistate, community-based pandemic response program that is consistent with existing Federal and State pandemic response plans;

(3) an assessment of the feasibility of using existing Federal and private insurance funding in establishing a multistate, school-based vaccination program for seasonal influenza vaccination;

(4) an assessment of the number of education days gained by students as a result of seasonal vaccinations based on absenteeism rates;

(5) a determination of whether the program under this section—

(A) increased vaccination rates in the participating localities; and

(B) was implemented for sufficient time for gathering enough valid data; and

(6) a recommendation on whether the program should be continued, expanded, or terminated.

(k) DEFINITIONS.—In this section:

(1) ELIGIBLE PARTNERSHIP.—The term ''eligible partnership'' means a local public health department, or another health organization defined by the Secretary as eligible to submit an application, and one or more elementary and secondary schools.

(2) ELEMENTARY SCHOOL.—The terms ''elementary school'' and ''secondary school'' have the meanings given such terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) LOW-INCOME.—The term ''low-income'' means a student, age 5 through 19, eligible for free or reduced-price lunch under the National School Lunch Act (42 U.S.C. 1751 et seq.).

(4) RURAL LOCAL EDUCATIONAL AGENCY.—The term ''rural local educational agency'' means an eligible local educational agency described in section 6211(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7345(b)(1)).

(5) SECRETARY.—Except as otherwise specified, the term ''Secretary'' means the Secretary of Health and Human Services.

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

SEC. 2525. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $70,000,000 for fiscal year 2011, $73,500,000 for fiscal year 2012, $77,000,000 for fiscal year 2013, $81,000,000 for fiscal year 2014, and $85,000,000 for fiscal year 2015.''.

SEC. 2526. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 317T the following:

''SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

''(a) PROGRAM.—To the extent and in the amount of appropriations made in advance in appropriations Acts, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program consisting of making grants, in amounts determined under subsection (c), to each State that submits an application in accordance with subsection (d) for an evidence-based education program described in subsection (b).

''(b) USE OF FUNDS.—Amounts received by a State under this section shall be used to conduct or support evidence-based education programs (directly or through grants or contracts to public or private nonprofit entities, including schools and community-based and faith-based organizations) to reduce teen pregnancy or sexually transmitted diseases.

''(c) DISTRIBUTION OF FUNDS.—The Director shall, for fiscal year 2011 and each subsequent fiscal year, make a grant to each State described in subsection (a) in an amount equal to the product of—

''(1) the amount appropriated to carry out this section for the fiscal year; and

''(2) the percentage determined for the State under section 502(c)(1)(B)(ii) of the Social Security Act.

''(d) APPLICATION.—To seek a grant under this section, a State shall submit an application at such time, in such manner, and containing such information and assurance of compliance with this section as the Secretary may require. At a minimum, an application shall to the satisfaction of the Secretary—

''(1) describe how the State's proposal will address the needs of at-risk teens in the State;

''(2) identify the evidence-based education program or programs selected from the registry developed under subsection (g) that will be used to address risks in priority populations;

''(3) describe how the program or programs will be implemented and any adaptations to the evidence-based model that will be made;

''(4) list any private and public entities with whom the State proposes to work, including schools and community-based and faith-based organizations, and demonstrate their capacity to implement the proposed program or programs; and

''(5) identify an independent entity that will evaluate the impact of the program or programs.

''(e) EVALUATION.—

''(1) REQUIREMENT.—As a condition on receipt of a grant under this section, a State shall agree—

''(A) to arrange for an independent evaluation of the impact of the programs to be conducted or supported through the grant; and

''(B) submit reports to the Secretary on such programs and the results of evaluation of such programs.

''(2) FUNDING LIMITATION.—Of the amounts made available to a State through a grant under this section for any fiscal year, not more than 10 percent may be used for such evaluation.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed to preempt or limit any State law regarding parental involvement and decisionmaking in children's education.

''(g) REGISTRY OF ELIGIBLE PROGRAMS.—The Secretary shall develop not later than 180 days after the date of the enactment of the Affordable Health Care for America Act, and periodically update thereafter, a publicly available registry of programs described in subsection (b) that, as determined by the Secretary—

''(1) meet the definition of the term 'evidence-based' in subsection (i);

''(2) are medically and scientifically accurate; and

''(3) provide age-appropriate information.

''(h) MATCHING FUNDS.—The Secretary may award a grant to a State under this section for a fiscal year only if the State agrees to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $4 provided through the grant to carry out the activities supported by the grant.

''(i) DEFINITION.—In this section, the term 'evidence-based' means based on a model that has been found, in methodologically sound research—

''(1) to delay initiation of sex;

''(2) to decrease number of partners;

''(3) to reduce teen pregnancy;

''(4) to reduce sexually transmitted infection rates; or

''(5) to improve rates of contraceptive use.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015.''.

SEC. 2527. NATIONAL TRAINING INITIATIVES ON AUTISM SPECTRUM DISORDERS.

Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) is amended by adding at the end the following:

''Subtitle F—National Training Initiative on Autism Spectrum Disorders

''SEC. 171. NATIONAL TRAINING INITIATIVE.

''(a) GRANTS AND TECHNICAL ASSISTANCE.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Interagency Autism Coordinating Committee, shall award multiyear grants to eligible entities to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism.

''(B) ELIGIBLE ENTITY.—To be eligible to receive a grant under this subsection, an entity shall be—

''(i) a University Center for Excellence in Developmental Disabilities Education, Research, and Service; or

''(ii) a comparable interdisciplinary education, research, and service entity.

''(C) APPLICATION REQUIREMENTS.—An entity that desires to receive a grant for a program under this paragraph shall submit to the Secretary an application—

''(i) demonstrating that the entity has capacity to—

''(I) provide training and technical assistance in evidence-based practices to evaluate, and provide effective interventions, services, treatments, and supports to, children and adults with autism and their families;

''(II) include individuals with autism and their families as part of the program to ensure that an individual- and family-centered approach is used;

''(III) share and disseminate materials and practices that are developed for, and evaluated to be effective in, the provision of training and technical assistance; and

''(IV) provide training, technical assistance, interventions, services, treatments, and supports under this subsection statewide.

''(ii) providing assurances that the entity will—

''(I) provide trainees under this subsection with an appropriate balance of interdisciplinary academic and community-based experiences; and

''(II) provide to the Secretary, in the manner prescribed by the Secretary, data regarding the number of individuals who have benefitted from, and outcomes of, the provision of training and technical assistance under this subsection;

''(iii) providing assurances that training, technical assistance, dissemination of information, and services under this subsection will be—

''(I) consistent with the goals of this Act, the Americans with Disabilities Act of 1990, the Individuals with Disabilities Education Act, and the Elementary and Secondary Education Act of 1965; and

''(II) conducted in coordination with relevant State agencies, institutions of higher education, and service providers; and

''(iv) containing such other information and assurances as the Secretary may require.

''(D) USE OF FUNDS.—A grant received under this subsection shall be used to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

''(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for, children and adults with autism.

''(ii) Developing model services and supports that demonstrate evidence-based practices.

''(iii) Developing systems and products that allow for the interventions, services, treatments, and supports to be evaluated for fidelity of implementation.

''(iv) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

''(v) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, autism advocacy groups, and community-based service providers.

''(vi) Working to develop comprehensive systems of supports and services for individuals with autism and their families, including seamless transitions between education and health systems across the lifespan.

''(vii) Promoting training, technical assistance, dissemination of information, supports, and services.

''(viii) Developing mechanisms to provide training and technical assistance, including for-credit courses, intensive summer institutes, continuing education programs, distance based programs, and Web-based information dissemination strategies.

''(ix) Promoting activities that support community-based family and individual services and enable individuals with autism and related developmental disabilities to fully participate in society and achieve good quality-of-life outcomes.

''(x) Collecting data on the outcomes of training and technical assistance programs to meet statewide needs for the expansion of services to children and adults with autism.

''(E) AMOUNT OF GRANTS.—The amount of a grant to any entity for a fiscal year under this section shall be not less than $250,000.

''(2) TECHNICAL ASSISTANCE.—The Secretary shall reserve 2 percent of the amount appropriated to carry out this subsection for a fiscal year to make a grant to a national organization with demonstrated capacity for providing training and technical assistance to—

''(A) assist in national dissemination of specific information, including evidence-based best practices, from interdisciplinary training programs, and when appropriate, other entities whose findings would inform the work performed by entities awarded grants;

''(B) compile and disseminate strategies and materials that prove to be effective in the provision of training and technical assistance so that the entire network can benefit from the models, materials, and practices developed in individual centers;

''(C) assist in the coordination of activities of grantees under this subsection;

''(D) develop a Web portal that will provide linkages to each of the individual training initiatives and provide access to training modules, promising training, and technical assistance practices and other materials developed by grantees;

''(E) serve as a research-based resource for Federal and State policymakers on information concerning the provision of training and technical assistance for the assessment, and provision of supports and services for, children and adults with autism;

''(F) convene experts from multiple interdisciplinary training programs, individuals with autism, and the families of such individuals to discuss and make recommendations with regard to training issues related to assessment, interventions, services, treatment, and supports for children and adults with autism; and

''(G) undertake any other functions that the Secretary determines to be appropriate.

''(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $17,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

''(b) EXPANSION OF THE NUMBER OF UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES EDUCATION, RESEARCH, AND SERVICE.—

''(1) GRANTS.—To provide for the establishment of up to 4 new University Centers for Excellence in Developmental Disabilities Education, Research, and Service, the Secretary shall award up to 4 grants to institutions of higher education.

''(2) APPLICABLE PROVISIONS.—Except for subsection (a)(3), the provisions of subsection (a) shall apply with respect to grants under this subsection to the same extent and in the same manner as such provisions apply with respect to grants under subsection (a).

''(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to applicants that—

''(A) are minority institutions that have demonstrated capacity to meet the requirements of this section and provide services to individuals with autism and their families; or

''(B) are located in a State with one or more underserved populations.

''(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $2,000,000 for each of fiscal years 2011 through 2015.

''(c) DEFINITIONS.—In this section:

''(1) The term 'autism' means an autism spectrum disorder or a related developmental disability.

''(2) The term 'interventions' means educational methods and positive behavioral support strategies designed to improve or ameliorate symptoms associated with autism.

''(3) The term 'minority institution' has the meaning given to such term in section 365 of the Higher Education Act of 1965.

''(4) The term 'services' means services to assist individuals with autism to live more independently in their communities.

''(5) The term 'treatments' means health services, including mental health services, designed to improve or ameliorate symptoms associated with autism.

''(6) The term 'University Center for Excellence in Developmental Disabilities Education, Research, and Service' means a University Center for Excellence in Development Disabilities Education, Research, and Service that has been or is funded through subtitle D or subsection (b).''.

SEC. 2528. IMPLEMENTATION OF MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Agency for Health Care Research and Quality, shall establish a program to provide grants to eligible entities to implement medication management services (referred to in this section as ''MTM services'') provided by licensed pharmacists, as a part of a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the grant program not later than May 1, 2011.

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

(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

(2) submit to the Secretary a plan for achieving long-term financial sustainability;

(3) where applicable, submit a plan for coordinating MTM services with other local providers and where applicable, through or in collaboration with the Medicare Medical Home Pilot program as established by section 1866F of the Social Security Act, as added by section 1302(a) of this Act;

(4) submit a plan for meeting the requirements under subsection (c); and

(5) submit to the Secretary such other information as the Secretary may require.

(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant awarded under subsection (a) shall, as allowed by State law (including applicable collaborative pharmacy practice agreements), include—

(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

(6) documenting the care delivered and communicating essential information about such care (including a summary of the medication review) and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

(10) such other patient care services as are allowed under the scopes of practice for pharmacists for purposes of other Federal programs.

(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant awarded under subsection (a) shall be offered to targeted individuals who—

(1) take 4 or more prescribed medications (including over-the-counter and dietary supplements);

(2) take any high-risk medications;

(3) have 2 or more chronic diseases, as identified by the Secretary; or

(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

(f) REPORTING TO THE SECRETARY.—An entity that receives a grant under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures, as determined by the Secretary.

(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

(2) assess changes in overall health care resource of targeted individuals;

(3) assess patient and prescriber satisfaction with MTM services;

(4) assess the impact of patient-cost-sharing requirements on medication adherence and recommendations for modifications;

(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

(h) GRANT TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.

SEC. 2529. POSTPARTUM DEPRESSION.

(a) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—

(1) CONTINUATION OF ACTIVITIES.—The Secretary is encouraged to expand and intensify activities on postpartum conditions.

(2) PROGRAMS FOR POSTPARTUM CONDITIONS.—In carrying out paragraph (1), the Secretary is encouraged to continue research to expand the understanding of the causes of, and treatments for, postpartum conditions, including conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health professionals and the public, which may include a coordinated national campaign that—

(i) is designed to increase the awareness and knowledge of postpartum conditions;

(ii) may include public service announcements through television, radio, and other means; and

(iii) may focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(b) REPORT BY THE SECRETARY.—

(1) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by paragraph (1) and submit a report to the Congress on the results of such study.

(c) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(1) SENSE OF CONGRESS.—It is the sense of the Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2011 through 2020) on the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(2) REPORT.—Beginning not later than 3 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(d) DEFINITIONS.—In this section:

(1) The term ''postpartum condition'' means postpartum depression or postpartum psychosis.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2013.

SEC. 2530. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

Part P of title III (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, especially racial and ethnic minority populations;

''(2) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

''(A) poor nutrition;

''(B) physical inactivity;

''(C) being overweight or obese;

''(D) tobacco use;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) risky sexual behavior;

''(H) untreated mental health problems;

''(I) untreated dental and oral health problems; and

''(J) understanding informed consent;

''(3) to educate and provide guidance regarding effective strategies to promote positive health behaviors within the family;

''(4) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(5) to educate and refer underserved populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services, and to eliminate duplicative care; or

''(6) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance is sought under this section;

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant, such program will provide training and supervision to community health workers to enable such workers to provide authorized program services;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

''(D) contain an assurance that each community health worker program receiving funds under the grant will provide services in the cultural context most appropriate for the individuals served by the program;

''(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

''(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

''(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

''(ii) providing other services as the Secretary determines to be appropriate, that may include transportation and translation services.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

''(B) with a high percentage of residents who suffer from chronic diseases including pulmonary conditions, hypertension, heart disease, mental disorders, diabetes, and asthma; and

''(C) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, especially those that graduate a disproportionate number of health and health care students from underrepresented racial and ethnic minority backgrounds. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement an outcome-based payment system that rewards community

health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served under such programs.

''(C) An evaluation of—

''(i) the effectiveness of such programs;

''(ii) the cost of such programs; and

''(iii) the impact of the programs on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health, including oral and mental, or nutrition needs; and

''(F) by providing referral and followup services or otherwise coordinating care.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant resides.

''(3) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State, United States territory or possession, or federally recognized Indian tribe—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.

''(4) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(5) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or private nonprofit entity (including a State or public subdivision of a State, a public health department, or a federally qualified health center), or a consortium of any of such entities, located in the United States or territory thereof.

''(l) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2011 through 2015.''.

SEC. 2531. MEDICAL LIABILITY ALTERNATIVES.

(a) INCENTIVE PAYMENTS FOR MEDICAL LIABILITY REFORM.—

(1) IN GENERAL.—To the extent and in the amounts made available in advance in appropriations Acts, the Secretary shall make an incentive payment, in an amount determined by the Secretary, to each State that has an alternative medical liability law in compliance with this section.

(2) DETERMINATION BY SECRETARY.—The Secretary shall determine that a State has an alternative medical liability law in compliance with this section if the Secretary is satisfied that—

(A) the State enacted the law after the date of the enactment of this Act and is implementing the law;

(B) the law is effective; and

(C) the contents of the law are in accordance with paragraph (4).

(3) CONSIDERATIONS FOR DETERMINING EFFECTIVENESS.—In determining whether an alternative medical liability law is effective under paragraph (2)(B), the Secretary shall consider whether the law—

(A) makes the medical liability system more reliable through prevention of, or prompt and fair resolution of, disputes;

(B) encourages the disclosure of health care errors; and

(C) maintains access to affordable liability insurance.

(4) CONTENTS OF ALTERNATIVE MEDICAL LIABILITY LAW.—The contents of an alternative liability law are in accordance with this paragraph if—

(A) the litigation alternatives contained in the law consist of certificate of merit, early offer, or both; and

(B) the law does not limit attorneys' fees or impose caps on damages.

(5) NO LIMITATION ON OTHER STATE LAWS.—Nothing in this section shall be construed to—

(A) preempt or modify the application of any existing State law that limits attorneys' fees or imposes caps on damages;

(B) impair the authority of a State to establish or implement a law limiting attorneys' fees or imposing caps on damages; or

(C) restrict the eligibility of a State for an incentive payment under this section on the basis of a law described in subparagraph (A) or (B) so long as any such law is not established or implemented as part of the law described in paragraph (4), as determined by the Secretary.

(b) USE OF INCENTIVE PAYMENTS.—Amounts received by a State as an incentive payment under this section shall be used to improve health care in that State.

(c) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to the States applying for or receiving an incentive payment under this section.

(d) REPORTS.—Beginning not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Congress an annual report on the progress States have made in enacting and implementing alternative medical liability laws in compliance with this section. Such reports shall contain sufficient documentation regarding the effectiveness of such laws to enable an objective comparative analysis of such laws.

(e) DEFINITION.—In this section—

(1) the term ''Secretary'' means the Secretary of Health and Human Services; and

(2) the term ''State'' includes the several States, District of Columbia, the Commonwealth of Puerto Rico, and each other territory or possession of the United States.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary, to remain available until expended.

SEC. 2532. INFANT MORTALITY PILOT PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director, shall award grants to eligible entities to create, implement, and oversee infant mortality pilot programs.

(b) PERIOD OF A GRANT.—The period of a grant under this section shall be 5 consecutive fiscal years.

(c) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to eligible entities proposing to serve any of the 15 counties or groups of counties with the highest rates of infant mortality in the United States in the past 3 years.

(d) USE OF FUNDS.—Any infant mortality pilot program funded under this section may—

(1) include the development of a plan that identifies the individual needs of each community to be served and strategies to address those needs;

(2) provide outreach to at-risk mothers through programs deemed appropriate by the Director;

(3) develop and implement standardized systems for improved access, utilization, and quality of social, educational, and clinical services to promote healthy pregnancies, full term births, and healthy infancies delivered to women and their infants, such as—

(A) counseling on infant care, feeding, and parenting;

(B) postpartum care;

(C) prevention of premature delivery; and

(D) additional counseling for at-risk mothers, including smoking cessation programs, drug treatment programs, alcohol treatment programs, nutrition and physical activity programs, postpartum depression and domestic violence programs, social and psychological services, dental care, and parenting programs;

(4) establish a rural outreach program to provide care to at-risk mothers in rural areas;

(5) establish a regional public education campaign, including a campaign to—

(A) prevent preterm births; and

(B) educate the public about infant mortality; and

(6) provide for any other activities, programs, or strategies as identified by the community plan.

(e) LIMITATION.—Of the funds received through a grant under this section for a fiscal year, an eligible entity shall not use more than 10 percent for program evaluation.

(f) REPORTS ON PILOT PROGRAMS.—

(1) IN GENERAL.—Not later than 1 year after receiving a grant, and annually thereafter for the duration of the grant period, each entity that receives a grant under subsection (a) shall submit a report to the Secretary detailing its infant mortality pilot program.

(2) CONTENTS OF REPORT.—The reports required under paragraph (1) shall include information such as the methodology of, and outcomes and statistics from, the grantee's infant mortality pilot program.

(3) EVALUATION.—The Secretary shall use the reports required under paragraph (1) to

evaluate, and conduct statistical research on, infant mortality pilot programs funded through this section.

(g) DEFINITIONS.—For the purposes of this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State, county, city, territorial, or tribal health department that has submitted a proposal to the Secretary that the Secretary deems likely to reduce infant mortality rates within the standard metropolitan statistical area involved.

(3) TRIBAL.—The term ''tribal'' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.

(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for each of fiscal years 2011 through 2015.

SEC. 2533. SECONDARY SCHOOL HEALTH SCIENCES TRAINING PROGRAM.

(a) PROGRAM.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, and in consultation with the Secretary of Education, may establish a health sciences training program consisting of awarding grants and contracts under subsection (b) to prepare secondary school students for careers in health professions.

(b) DEVELOPMENT AND IMPLEMENTATION OF HEALTH SCIENCES CURRICULA.—The Secretary may make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, or implement secondary school health sciences curricula, including curricula in biology, chemistry, physiology, mathematics, nutrition, and other courses deemed appropriate by the Secretary to prepare students for associate's or bachelor's degree programs in health professions or bachelor's degree programs in health professions-related majors; and

(2) to increase the interest of secondary school students in applying to, and enrolling in, accredited associate's or bachelor's degree programs in health professions or bachelor's degree programs in health professions-related majors, including through—

(A) work-study programs;

(B) programs to increase awareness of careers in health professions; and

(C) other activities to increase such interest.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall—

(1) be a local educational agency; and

(2) provide assurances that activities under the grant or contract will be carried out in partnership with an accredited health professions school or program, public or private nonprofit hospital, or public or private nonprofit entity.

(d) PREFERENCE.—In awarding grants and contracts under subsection (b), the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Graduating a high or significantly improved percentage of students who have exhibited mastery in secondary school State science standards.

(2) Graduating students from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented in—

(A) associate's or bachelor's degree programs in health professions or bachelor's degree programs in health professions-related majors; or

(B) health professions.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

(f) DEFINITIONS.—In this section:

(1) The term ''health profession'' means the profession of any member of the health workforce, as defined in section 764(i) of the Public Health Service Act, as added by section 2261.

(2) The term ''local educational agency'' has the meaning given to the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) The term ''secondary school''—

(A) means a secondary school, as defined in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801); and

(B) includes any such school that is a middle school.

(4) The term ''Secretary'' means the Secretary of Health and Human Services except as otherwise specified.

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

SEC. 2534. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

(a) PURPOSE.—The purpose of this subtitle is to establish and provide assistance to community-based collaborative care networks—

(1) to develop or strengthen coordination of services to allow all individuals, including the uninsured and low-income, to receive efficient and higher quality care and to gain entry into and receive services from a comprehensive system of care;

(2) to develop efficient and sustainable infrastructure for a health care delivery system characterized by effective collaboration, information sharing, and clinical and financial coordination among providers of care in the community;

(3) to develop or strengthen activities related to providing coordinated care for individuals with chronic conditions; and

(4) to reduce the use of emergency departments, inpatient and other expensive resources of hospitals and other providers.

(b) CREATION OF THE COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.—Part D of title III (42 U.S.C. 254b et seq.), as amended, is further amended by inserting after subpart XII the following new subpart:

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

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

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

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

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

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

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

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

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

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

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

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

''(b) ELIGIBILITY AND GRANTEE SELECTION.—

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

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

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

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

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

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

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

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

''(2) SELECTION OF GRANTEES.—

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

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

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

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

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

''(3) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a

community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services, if such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

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

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

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

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

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

''(c) USE OF FUNDS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(1) IN GENERAL.—

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

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

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

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

''(C) ADDITIONAL INCLUSIONS.—Each such network may include any of the following additional providers:

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

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

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

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

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

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

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

''(viii) An adult day care center.

''(ix) A home health provider.

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

''(D) CONSTRUCTION.—

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

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

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

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

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

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

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

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

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

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

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

''(e) EVALUATIONS.—

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

''(A) the number of people served;

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 2535. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

Part Q of title III (42 U.S.C. 280h et seq.) is amended by inserting after section 399W the following:

''SEC. 399W–1. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

''(a) PROGRAM.—The Secretary shall establish a community-based overweight and obesity prevention program consisting of awarding grants and contracts under subsection (b).

''(b) GRANTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to plan evidence-based programs for the prevention of overweight and obesity among children and their families through improved nutrition and increased physical activity; or

''(2) to implement such programs.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be a community partnership that demonstrates community support and includes—

''(1) a broad cross section of stakeholders, such as—

''(A) hospitals, health care systems, community health centers, or other health care providers;

''(B) universities, local educational agencies, or childcare providers;

''(C) State, local, and tribal health departments;

''(D) State, local, and tribal park and recreation departments;

''(E) employers; and

''(F) health insurance companies;

''(2) residents of the community; and

''(3) representatives of public and private entities that have a history of working within and serving the community.

''(d) PERIOD OF AWARDS.—

''(1) IN GENERAL.—The period of a grant or contract under this section shall be 5 years, subject to renewal under paragraph (2).

''(2) RENEWAL.—At the end of each fiscal year, the Secretary may renew a grant or contract award under this section only if the grant or contract recipient demonstrates to the Secretary's satisfaction that the recipient has made appropriate, measurable progress in preventing overweight and obesity.

''(e) REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the Secretary's satisfaction that—

''(A) not later than 90 days after receiving the grant or contract, the entity will establish a steering committee to provide input on the assessment of, and recommendations on improvements to, the entity's program funded through the grant or contract; and

''(B) the entity has conducted or will conduct an assessment of the overweight and obesity problem in its community, including the extent of the problem and factors contributing to the problem.

''(2) MATCHING REQUIREMENT.—The Secretary may award a grant or contract to an eligible entity under this section only if the entity agrees to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $9 provided through the grant or contract to carry out the activities supported by the grant or contract.

''(3) PAYOR OF LAST RESORT.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that funds received through the grant or contract will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(4) MAINTENANCE OF EFFORT.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that—

''(A) funds received through the grant or contract will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the activities to be funded through the grant or contract; and

''(B) with respect to such activities, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the lesser of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant or contract.

''(f) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to eligible entities that—

''(1) will serve communities with high levels of overweight and obesity and related chronic diseases; or

''(2) will plan or implement activities for the prevention of overweight and obesity in school or workplace settings.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants and contracts awarded under this section.

''(h) DEFINITIONS.—In this section:

''(1) The term 'evidence-based' means that methodologically sound research has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children's Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

''(2) The term 'local educational agency' has the meaning given to the term in section 9101 of the Elementary and Secondary Education Act of 1965.

''(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.''.

SEC. 2536. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education, in consultation with the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention, may make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies that demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the agency, in part by providing information on current ratios of students to school nurses.

(3) MATCHING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(b) REPORT.—Not later than 24 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(c) DEFINITIONS.—For purposes of this section:

(1) The terms ''elementary school'', ''local educational agency'', and ''secondary school'' have the meanings given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term ''eligible local educational agency'' means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students to every school nurse.

(3) The term ''high-need local educational agency'' means a local educational agency—

(A) that serves not fewer than 10,000 children from families with incomes below the poverty line; or

(B) for which not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(4) The term ''nurse'' means a licensed nurse, as defined under State law.

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

SEC. 2537. MEDICAL-LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish a nationwide demonstration project consisting of—

(1) awarding grants to, and entering into contracts with, medical-legal partnerships to assist patients and their families to navigate health-related programs and activities; and

(2) evaluating the effectiveness of such partnerships.

(b) USE OF FUNDS.—Amounts received as a grant or contract under this section shall be used to assist patients and their families to navigate health care-related programs and activities and thereby achieve one or more of the following goals:

(1) Enhancing access to health care services.

(2) Improving health outcomes for low-income individuals.

(3) Reducing health disparities.

(4) Enhancing wellness and prevention of chronic conditions.

(c) PROHIBITION.—No funds under this section may be used—

(1) for any medical malpractice or other civil action or proceeding; or

(2) to assist individuals who are not lawfully present in the United States.

(d) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a report to the Congress on the results of the demonstration project under this section. Such report shall include the following:

(1) A description of the extent to which medical-legal partnerships funded through this section achieved the goals described in subsection (b).

(2) Recommendations on the possibility of extending or expanding the demonstration project.

(e) DEFINITIONS.—In this section:

(1) The term ''health disparities'' has the meaning given to the term in section 3171 of the Public Health Service Act, as added by section 2301.

(2) The term ''medical-legal partnership'' means an entity—

(A) that is a collaboration between—

(i) a community health center, public hospital, children's hospital, or other provider of health care services to a significant number of low-income beneficiaries; and

(ii) one or more attorneys; and

(B) whose primary mission is to assist patients and their families navigate health care-related programs and activities.

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

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

SEC. 2538. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

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

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

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

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

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

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

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

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

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

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

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

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

''(1) provides primary health services;

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

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

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

''(5) agrees—

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

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

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

''(1) provide services in rural or frontier areas of the Nation;

''(2) provide services to special needs populations, including American Indian or Alaska Native populations; or

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

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

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

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

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

''(g) AUTHORIZATION OF APPROPRIATIONS.—

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

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

SEC. 2539. GRANTS TO ASSIST IN DEVELOPING MEDICAL SCHOOLS IN FEDERALLY-DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services may make grants to nonprofit organizations or institutions of higher education for the purpose of assisting the organization or institution involved to develop a medical school if—

(1) the medical school will be located in an area that is designated (under section 332 of the Public Health Service Act (42 U.S.C. 254(e)) as a health professional shortage area;

(2) the organization or institution provides assurances satisfactory to the Secretary of substantial private or public funding from non-Federal sources for the development of the medical school; and

(3) the organization or institution provides assurances satisfactory to the Secretary that accreditation will be achieved for the medical school.

(b) USE OF GRANT FUNDS.—Grants awarded under this section may be used for the acquisition and building of the medical school campus in a health professional shortage area and the purchase of equipment, curriculum and faculty development, and general operations related to the development and establishment of the medical school.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $100,000,000 for each of fiscal years 2011 through 2015.

Page 1523, strike lines 5 through 17 and insert the following:

''(i) IN GENERAL.—A violation of subparagraph (A) shall be subject to enforcement by the Federal Trade Commission in the same manner, by the same means, and with the same jurisdiction as would an unfair and deceptive act or practice in or affecting interstate commerce or an unfair method of competition in or affecting interstate commerce prohibited under section 5 of the Federal Trade Commission Act, as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this subsection.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

SEC. 2551. TRAUMA CARE CENTERS.

(a) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 (42 U.S.C. 300d–41) is amended to read as follows:

''SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.

''(a) IN GENERAL.—The Secretary shall establish a trauma center program consisting of awarding grants under section (b).

''(b) GRANTS.—The Secretary shall award grants as follows:

''(1) EXISTING CENTERS.—Grants to public, private nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers—

''(A) to further the core missions of such centers; or

''(B) to provide emergency relief to ensure the continued and future availability of trauma services by trauma centers—

''(i) at risk of closing or operating in an area where a closing has occurred within their primary service area; or

''(ii) in need of financial assistance following a natural disaster or other catastrophic event, such as a terrorist attack.

''(2) NEW CENTERS.—Grants to local governments and public or private nonprofit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes.

''(c) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

''(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—

''(A) LIMITATION.—Subject to subparagraph (B), the Secretary may not award a grant to an existing trauma center under this section unless the center is a participant in a trauma care system that substantially complies with section 1213.

''(B) EXEMPTION.—Subparagraph (A) shall not apply to trauma centers that are located in States with no existing trauma care system.

''(2) DESIGNATION.—The Secretary may not award a grant under this section to an existing trauma center unless the center is—

''(A) verified as a trauma center by the American College of Surgeons; or

''(B) designated as a trauma center by the applicable State health or emergency medical services authority.''.

(b) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 (42 U.S.C. 300d–42) is amended to read as follows:

''SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.

''(a) CORE MISSION AWARDS.—

''(1) IN GENERAL.—In awarding grants under section 1241(b)(1)(A), the Secretary shall—

''(A) reserve a minimum of 25 percent of the amount allocated for such grants for level III and level IV trauma centers in rural or underserved areas;

''(B) reserve a minimum of 25 percent of the amount allocated for such grants for level I and level II trauma centers in urban areas; and

''(C) give preference to any application made by a trauma center—

''(i) in a geographic area where growth in demand for trauma services exceeds capacity;

''(ii) that demonstrates the financial support of the State or political subdivision involved;

''(iii) that has at least 1 graduate medical education fellowship in trauma or trauma-related specialties, including neurological surgery, surgical critical care, vascular surgery, and spinal cord injury, for which demand is exceeding supply; or

''(iv) that demonstrates a substantial commitment to serving vulnerable populations.

''(2) FINANCIAL SUPPORT.—For purposes of paragraph (1)(C)(ii), financial support may be demonstrated by State or political subdivision funding for the trauma center's capital or operating expenses (including through State trauma regional advisory coordination activities, Medicaid funding designated for trauma services, or other governmental funding). State funding derived from Federal support shall not constitute State or local financial support for purposes of preferential treatment under this subsection.

''(3) USE OF FUNDS.—The recipient of a grant under section 1241(b)(1)(A) shall carry out, consistent with furthering the core missions of the center, one or more of the following activities:

''(A) Providing 24-hour-a-day, 7-day-a-week trauma care availability.

''(B) Reducing overcrowding related to throughput of trauma patients.

''(C) Enhancing trauma surge capacity.

''(D) Ensuring physician and essential personnel availability.

''(E) Trauma education and outreach.

''(F) Coordination with local and regional trauma care systems.

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

''(b) EMERGENCY AWARDS; NEW CENTERS.—In awarding grants under paragraphs (1)(B) and (2) of section 1241(b), the Secretary shall—

''(1) give preference to any application submitted by an applicant that demonstrates the financial support (in accordance with subsection (a)(2)) of the State or political subdivision involved for the activities to be funded through the grant for each fiscal year during which payments are made to the center under the grant; and

''(2) give preference to any application submitted for a trauma center that—

''(A) is providing or will provide trauma care in a geographic area in which the availability of trauma care has either significantly decreased as a result of a trauma center in the area permanently ceasing participation in a system described in section 1241(c)(1) as of a date occurring during the 2-year period preceding the fiscal year for which the trauma center is applying to receive a grant, or in geographic areas where growth in demand for trauma services exceeds capacity;

''(B) will, in providing trauma care during the 1-year period beginning on the date on which the application for the grant is submitted, incur substantial uncompensated care costs in an amount that renders the center unable to continue participation in such system and results in a significant decrease in the availability of trauma care in the geographic area;

''(C) operates or will operate in rural areas where trauma care availability will significantly decrease if the center is forced to close or downgrade service and substantial costs are contributing to a likelihood of such closure or downgradation;

''(D) is in a geographic location substantially affected by a natural disaster or other catastrophic event such as a terrorist attack; or

''(E) will establish a new trauma service in an urban area with a substantial degree of trauma resulting from violent crimes.

''(c) DESIGNATIONS OF LEVELS OF TRAUMA CENTERS IN CERTAIN STATES.—In the case of a State which has not designated 4 levels of trauma centers, any reference in this section to—

''(1) a level I or level II trauma center is deemed to be a reference to a trauma center within the highest 2 levels of trauma centers designated under State guidelines; and

''(2) a level III or IV trauma center is deemed to be a reference to a trauma center not within such highest 2 levels.''.

(c) CERTAIN AGREEMENTS.—Section 1243 (42 U.S.C. 300d–43) is amended to read as follows:

''SEC. 1243. CERTAIN AGREEMENTS.

''(a) COMMITMENT REGARDING CONTINUED PARTICIPATION IN TRAUMA CARE SYSTEM.—The Secretary may not award a grant to an applicant under section 1241(b) unless the applicant agrees that—

''(1) the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

''(2) if the agreement made pursuant to paragraph (1) is violated by the center, the center will be liable to the United States for an amount equal to the sum of—

''(A) the amount of assistance provided to the center under section 1241; and

''(B) an amount representing interest on the amount specified in subparagraph (A).

''(b) MAINTENANCE OF FINANCIAL SUPPORT.—With respect to activities for which funds awarded through a grant under section 1241 are authorized to be expended, the Secretary may not award such a grant unless the applicant agrees that, during the period in which the trauma center involved is receiving payments under the grant, the center will maintain access to trauma services at levels not less than the levels for the prior year, taking into account—

''(1) reasonable volume fluctuation that is not caused by intentional trauma boundary reduction;

''(2) downgrading of the level of services; and

''(3) whether such center diverts its incoming patients away from such center 5 percent or more of the time during which the center is in operation over the course of the year.

''(c) TRAUMA CARE REGISTRY.—The Secretary may not award a grant to a trauma center under section 1241(b)(1) unless the center agrees that—

''(1) not later than 6 months after the date on which the center submits a grant application to the Secretary, the center will establish and operate a registry of trauma cases in accordance with guidelines developed by the American College of Surgeons; and

''(2) in carrying out paragraph (1), the center will maintain information on the number of trauma cases treated by the center and, for each such case, the extent to which the center incurs uncompensated costs in providing trauma care.''.

(d) GENERAL PROVISIONS.—Section 1244 (42 U.S.C. 300d–44) is amended to read as follows:

''SEC. 1244. GENERAL PROVISIONS.

''(a) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(b)(1) shall be for 3 fiscal years, except that the Secretary may waive such requirement for the center and authorize the center to receive such payments for 1 additional fiscal year.

''(b) ELIGIBILITY.—The acquisition of, or eligibility for, a grant under section 1241(b) shall not preclude a trauma center's eligibility for another grant described in such section.

''(c) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245—

''(1) 90 percent shall be used for grants under paragraph (1)(A) of section 1241(b); and

''(2) 10 percent shall be used for grants under paragraphs (1)(B) and (2) of section 1241(b).

''(d) REPORT.—Beginning 2 years after the date of the enactment of the Affordable Health Care for America Act, and every 2 years thereafter, the Secretary shall biennially—

''(1) report to Congress on the status of the grants made pursuant to section 1241;

''(2) evaluate and report to Congress on the overall financial stability of trauma centers in the United States;

''(3) report on the populations using trauma care centers and include aggregate patient data on income, race, ethnicity, and geography; and

''(4) evaluate the effectiveness and efficiency of trauma care center activities using standard public health measures and evaluation methodologies.''.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 (42 U.S.C. 300d–45) is amended to read as follows:

''SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.

''(b) REALLOCATION.—The Secretary shall reallocate for grants under section 1241(b)(1)(A) any funds appropriated for grants under paragraph (1)(B) or (2) of section 1241(b), but not obligated due to insufficient applications eligible for funding.''.

SEC. 2552. EMERGENCY CARE COORDINATION.

(a) IN GENERAL.—Subtitle B of title XXVIII (42 U.S.C. 300hh–10 et seq.) is amended by adding at the end the following:

''SEC. 2816. EMERGENCY CARE COORDINATION.

''(a) EMERGENCY CARE COORDINATION CENTER.—

''(1) ESTABLISHMENT.—The Secretary shall establish, within the Office of the Assistant Secretary for Preparedness and Response, an Emergency Care Coordination Center (in this section referred to as the 'Center'), to be headed by a director.

''(2) DUTIES.—The Secretary, acting through the Director of the Center, in coordination with the Federal Interagency

Committee on Emergency Medical Services, shall—

''(A) promote and fund research in emergency medicine and trauma health care;

''(B) promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and

''(C) promote local, regional, and State emergency medical systems' preparedness for and response to public health events.

''(b) COUNCIL OF EMERGENCY CARE.—

''(1) ESTABLISHMENT.—The Secretary, acting through the Director of the Center, shall establish a Council of Emergency Care to provide advice and recommendations to the Director on carrying out this section.

''(2) COMPOSITION.—The Council shall be comprised of employees of the departments and agencies of the Federal Government who are experts in emergency care and management.

''(c) REPORT.—

''(1) SUBMISSION.—Not later than 12 months after the date of the enactment of the Affordable Health Care for America Act, the Secretary shall submit to the Congress an annual report on the activities carried out under this section.

''(2) CONSIDERATIONS.—In preparing a report under paragraph (1), the Secretary shall consider factors including—

''(A) emergency department crowding and boarding; and

''(B) delays in care following presentation.

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

(b) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Emergency Care Coordination Center, as in existence on the day before the date of the enactment of this Act, shall be transferred to the Emergency Care Coordination Center established under section 2816(a) of the Public Health Service Act, as added by subsection (a).

SEC. 2553. PILOT PROGRAMS TO IMPROVE EMERGENCY MEDICAL CARE.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

''SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

''(b) ELIGIBLE ENTITY; REGION.—

''(1) ELIGIBLE ENTITY.—In this section, the term 'eligible entity' means a State or a partnership of 1 or more States and 1 or more local governments.

''(2) REGION.—In this section, the term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(c) DEMONSTRATION PROGRAM.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a demonstration program to design, implement, and evaluate an emergency medical system that—

''(1) coordinates with public safety services, public health services, emergency medical services, medical facilities, and other entities within a region;

''(2) coordinates an approach to emergency medical system access throughout the region, including 9–1–1 public safety answering points and emergency medical dispatch;

''(3) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the correct patient is taken to the medically appropriate facility (whether an initial facility or a higher level facility) in a timely fashion;

''(4) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(5) includes a consistent regionwide prehospital, hospital, and interfacility data management system that—

''(A) complies with the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State office of emergency medical services (or equivalent State office);

''(ii) is compatible with the applicable State emergency medical services system;

''(iii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iv) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(v) includes a categorization or designation system for special medical facilities throughout the region that is—

''(I) consistent with State laws and regulations; and

''(II) integrated with the protocols for transport and destination throughout the region; and

''(vi) includes a regional medical direction system, a patient tracking system, and a resource allocation system that—

''(I) support day-to-day emergency care system operation;

''(II) can manage surge capacity during a major event or disaster; and

''(III) are integrated with other components of the national and State emergency preparedness system;

''(B) an agreement to make available non-Federal contributions in accordance with subsection (e); and

''(C) such other information as the Secretary may require.

''(e) MATCHING FUNDS.—

''(1) IN GENERAL.—With respect to the costs of the activities to be carried out each year with a contract or grant under subsection (a), a condition for the receipt of the contract or grant is that the eligible entity involved agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved population (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a demonstration program under subsection (a), the recipient of such contract or grant described in such subsection shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care system on patient outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care system;

''(4) the State and local legislation necessary to implement and to maintain the system; and

''(5) the barriers to developing regionalized, accountable emergency care systems, as well as the methods to overcome such barriers.

''(h) EVALUATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall enter into a contract with an academic institution or other entity to conduct an independent evaluation of the demonstration programs funded under subsection (a), including an evaluation of—

''(1) the performance of the eligible entities receiving the funds; and

''(2) the impact of the demonstration programs.

''(i) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate committees of the Congress, the information contained in a report made under subsection (h).

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $12,000,000 for each of fiscal years 2011 through 2015.

''(2) RESERVATION.—Of the amount appropriated to carry out this section for a fiscal year, the Secretary shall reserve 3 percent of such amount to carry out subsection (h) (relating to an independent evaluation).''.

SEC. 2554. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO BECOME STATE-LICENSED OR CERTIFIED EMERGENCY MEDICAL TECHNICIANS (EMTS).

(a) IN GENERAL.—Part B of title III (42 U.S.C. 243 et seq.), as amended, is amended by inserting after section 315 the following:

''SEC. 315A. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO BECOME STATE-LICENSED OR CERTIFIED EMERGENCY MEDICAL TECHNICIANS (EMTS).

''(a) PROGRAM.—The Secretary shall establish a program consisting of awarding grants to States to assist veterans who received and completed military emergency medical training while serving in the Armed Forces of the United States to become, upon their

discharge or release from active duty service, State-licensed or certified emergency medical technicians.

''(b) USE OF FUNDS.—Amounts received as a grant under this section may be used to assist veterans described in subsection (a) to become State-licensed or certified emergency medical technicians as follows:

''(1) Providing training.

''(2) Providing reimbursement for costs associated with—

''(A) training; or

''(B) applying for licensure or certification.

''(3) Expediting the licensing or certification process.

''(c) ELIGIBILITY.—To be eligible for a grant under this section, a State shall demonstrate to the Secretary's satisfaction that the State has a shortage of emergency medical technicians.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

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

(b) GAO STUDY AND REPORT.—The Comptroller General of the United States shall—

(1) conduct a study on the barriers experienced by veterans who received training as medical personnel while serving in the Armed Forces of the United States and, upon their discharge or release from active duty service, seek to become licensed or certified in a State as civilian health professionals; and

(2) not later than 2 years after the date of the enactment of this Act, submit to the Congress a report on the results of such study, including recommendations on whether the program established under section 315A of the Public Health Service Act, as added by subsection (a), should be expanded to assist veterans seeking to become licensed or certified in a State as health providers other than emergency medical technicians.

SEC. 2555. DENTAL EMERGENCY RESPONDERS: PUBLIC HEALTH AND MEDICAL RESPONSE.

(a) NATIONAL HEALTH SECURITY STRATEGY.—Section 2802(b)(3) (42 U.S.C. 300hh–1(b)(3)) is amended—

(1) in the matter preceding subparagraph (A), by inserting ''dental and'' before ''mental health facilities''; and

(2) in subparagraph (D), by inserting ''and dental'' after ''medical''.

(b) ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RESPONSE CURRICULA AND TRAINING.—Section 319F(a)(5)(B) (42 U.S.C. 247d–6(a)(5)(B)) is amended by striking ''public health or medical'' and inserting ''public health, medical, or dental''.

SEC. 2556. DENTAL EMERGENCY RESPONDERS: HOMELAND SECURITY.

(a) NATIONAL RESPONSE FRAMEWORK.—Paragraph (6) of section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101) is amended by inserting ''and dental'' after ''emergency medical''.

(b) NATIONAL PREPAREDNESS SYSTEM.—Subparagraph (B) of section 653(b)(4) of the Post-Katrina Emergency Management Reform Act of 2006 (6 U.S.C. 753(b)(4)) is amended by striking ''public health and medical'' and inserting ''public health, medical, and dental''.

(c) CHIEF MEDICAL OFFICER.—Paragraph (5) of section 516(c) of the Homeland Security Act of 2002 (6 U.S.C. 321e(c)) is amended by striking ''medical community'' and inserting ''medical and dental communities''.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

SEC. 2561. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.

(a) CONVENING.—Not later than June 30, 2011, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this section referred to as ''the Conference'').

(b) PURPOSES.—The purposes of the Conference shall be to—

(1) increase the recognition of pain as a significant public health problem in the United States;

(2) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(3) identify barriers to appropriate pain care, including—

(A) lack of understanding and education among employers, patients, health care providers, regulators, and third-party payors;

(B) barriers to access to care at the primary, specialty, and tertiary care levels, including barriers—

(i) specific to those populations that are disproportionately undertreated for pain;

(ii) related to physician concerns over regulatory and law enforcement policies applicable to some pain therapies; and

(iii) attributable to benefit, coverage, and payment policies in both the public and private sectors; and

(C) gaps in basic and clinical research on the symptoms and causes of pain, and potential assessment methods and new treatments to improve pain care; and

(4) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(c) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under subsection (a), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(d) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2012.

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

SEC. 2562. PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.

Part B of title IV (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

''SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives as follows:

''(I) The Director of the Centers for Disease Control and Prevention.

''(II) The Director of the National Institutes of Health and the directors of such national research institutes and national centers as the Secretary determines appropriate.

''(III) The heads of such other agencies of the Department of Health and Human Services as the Secretary determines appropriate.

''(IV) Representatives of other Federal agencies that conduct or support pain care research and treatment, including the Department of Defense and the Department of Veterans Affairs.

''(ii) Twelve additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) Six members shall be appointed from among scientists, physicians, and other health professionals, who—

''(I) are not officers or employees of the United States;

''(II) represent multiple disciplines, including clinical, basic, and public health sciences;

''(III) represent different geographical regions of the United States; and

''(IV) are from practice settings, academia, manufacturers, or other research settings.

''(ii) Six members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies, including the Department of Defense and the Department of Veteran Affairs, are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities, including Federal agencies, and private entities to expand collaborative, crosscutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

SEC. 2563. PUBLIC AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

Part B of title II (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

''SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

''(a) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this section, the Secretary shall establish and implement a national pain care education outreach and awareness campaign described in subsection (b).

''(b) REQUIREMENTS.—The Secretary shall design the public awareness campaign under this section to educate consumers, patients, their families, and other caregivers with respect to—

''(1) the incidence and importance of pain as a national public health problem;

''(2) the adverse physical, psychological, emotional, societal, and financial consequences that can result if pain is not appropriately assessed, diagnosed, treated, or managed;

''(3) the availability, benefits, and risks of all pain treatment and management options;

''(4) having pain promptly assessed, appropriately diagnosed, treated, and managed, and regularly reassessed with treatment adjusted as needed;

''(5) the role of credentialed pain management specialists and subspecialists, and of comprehensive interdisciplinary centers of treatment expertise;

''(6) the availability in the public, nonprofit, and private sectors of pain management-related information, services, and resources for consumers, employers, third-party payors, patients, their families, and caregivers, including information on—

''(A) appropriate assessment, diagnosis, treatment, and management options for all types of pain and pain-related symptoms; and

''(B) conditions for which no treatment options are yet recognized; and

''(7) other issues the Secretary deems appropriate.

''(c) CONSULTATION.—In designing and implementing the public awareness campaign required by this section, the Secretary shall consult with organizations representing patients in pain and other consumers, employers, physicians including physicians specializing in pain care, other pain management professionals, medical device manufacturers, and pharmaceutical companies.

''(d) COORDINATION.—

''(1) LEAD OFFICIAL.—The Secretary shall designate one official in the Department of Health and Human Services to oversee the campaign established under this section.

''(2) AGENCY COORDINATION.—The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

''(e) UNDERSERVED AREAS AND POPULATIONS.—In designing the public awareness campaign under this section, the Secretary shall—

''(1) take into account the special needs of geographic areas and racial, ethnic, gender, age, and other demographic groups that are currently underserved; and

''(2) provide resources that will reduce disparities in access to appropriate diagnosis, assessment, and treatment.

''(f) GRANTS AND CONTRACTS.—The Secretary may make awards of grants, cooperative agreements, and contracts to public agencies and private nonprofit organizations to assist with the development and implementation of the public awareness campaign under this section.

''(g) EVALUATION AND REPORT.—Not later than the end of fiscal year 2012, the Secretary shall prepare and submit to the Congress a report evaluating the effectiveness of the public awareness campaign under this section in educating the general public with respect to the matters described in subsection (b).

''(h) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 and 2015.''.

Subtitle C—Food and Drug Administration

PART 1—IN GENERAL

SEC. 2571. NATIONAL MEDICAL DEVICE REGISTRY.

(a) REGISTRY.—

(1) IN GENERAL.—Section 519 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is amended—

(A) by redesignating subsection (g) as subsection (h); and

(B) by inserting after subsection (f) the following:

''National Medical Device Registry

''(g)(1)(A) The Secretary shall establish a national medical device registry (in this subsection referred to as the 'registry') to facilitate analysis of postmarket safety and outcomes data on each covered device.

''(B) In this subsection, the term 'covered device'—

''(i) shall include each class III device; and

''(ii) may include, as the Secretary determines appropriate and specifies in regulation, a class II device that is life-supporting or life-sustaining.

''(C) Notwithstanding subparagraph (B)(i), the Secretary may by order exempt a class III device from the provisions of this subsection if the Secretary concludes that inclusion of information on the device in the registry will not provide useful information on safety or effectiveness.

''(2) In developing the registry, the Secretary shall, in consultation with the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Agency for Healthcare Research and Quality, the head of the Office of the National Coordinator for Health Information Technology, and the Secretary of Veterans Affairs, determine the best methods for—

''(A) including in the registry, in a manner consistent with subsection (f), appropriate information to identify each covered device by type, model, and serial number or other unique identifier;

''(B) validating methods for analyzing patient safety and outcomes data from multiple sources and for linking such data with the information included in the registry as described in subparagraph (A), including, to the extent feasible, use of—

''(i) data provided to the Secretary under other provisions of this chapter; and

''(ii) information from public and private sources identified under paragraph (3);

''(C) integrating the activities described in this subsection (so as to avoid duplication) with—

''(i) activities under paragraph (3) of section 505(k) (relating to active postmarket risk identification);

''(ii) activities under paragraph (4) of section 505(k) (relating to advanced analysis of drug safety data);

''(iii) other postmarket device surveillance activities of the Secretary authorized by this chapter; and

''(iv) registries carried out by or for the Agency for Healthcare Research and Quality; and

''(D) providing public access to the data and analysis collected or developed through the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(3)(A) To facilitate analyses of postmarket safety and patient outcomes for covered devices, the Secretary shall, in collaboration with public, academic, and private entities, develop methods to—

''(i) obtain access to disparate sources of patient safety and outcomes data, including—

''(I) Federal health-related electronic data (such as data from the Medicare program under title XVIII of the Social Security Act or from the health systems of the Department of Veterans Affairs);

''(II) private sector health-related electronic data (such as pharmaceutical purchase data and health insurance claims data); and

''(III) other data as the Secretary deems necessary to permit postmarket assessment of device safety and effectiveness; and

''(ii) link data obtained under clause (i) with information in the registry.

''(B) In this paragraph, the term 'data' refers to information respecting a covered device, including claims data, patient survey data, standardized analytic files that allow for the pooling and analysis of data from disparate data environments, electronic health records, and any other data deemed appropriate by the Secretary.

''(4) The Secretary shall promulgate regulations for establishment and operation of the registry under paragraph (1). Such regulations—

''(A)(i) in the case of covered devices that are sold on or after the date of the enactment of this subsection, shall require manufacturers of such devices to submit information to the registry, including, for each such device, the type, model, and serial number or, if required under subsection (f), other unique device identifier; and

''(ii) in the case of covered devices that are sold before such date, may require manufacturers of such devices to submit such information to the registry, if deemed necessary by the Secretary to protect the public health;

''(B) shall establish procedures—

''(i) to permit linkage of information submitted pursuant to subparagraph (A) with patient safety and outcomes data obtained under paragraph (3); and

''(ii) to permit analyses of linked data;

''(C) may require covered device manufacturers to submit such other information as is necessary to facilitate postmarket assessments of device safety and effectiveness and notification of device risks;

''(D) shall establish requirements for regular and timely reports to the Secretary, which shall be included in the registry, concerning adverse event trends, adverse event patterns, incidence and prevalence of adverse events, and other information the Secretary determines appropriate, which may include data on comparative safety and outcomes trends; and

''(E) shall establish procedures to permit public access to the information in the registry in a manner and form that protects patient privacy and proprietary information

and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(5)(A) The Secretary shall promulgate final regulations under paragraph (4) not later than 36 months after the date of the enactment of this subsection.

''(B) Before issuing the notice of proposed rulemaking preceding the final regulations described in subparagraph (A), the Secretary shall hold a public hearing before an advisory committee on the issue of which class II devices to include in the definition of covered devices.

''(C) The Secretary shall include in any regulation under this subsection an explanation demonstrating that the requirements of such regulation—

''(i) do not duplicate other Federal requirements; and

''(ii) do not impose an undue burden on device manufacturers.

''(6) With respect to any entity that submits or is required to submit a safety report or other information in connection with the safety of a device under this section (and any release by the Secretary of that report or information), such report or information shall not be construed to reflect necessarily a conclusion by the entity or the Secretary that the report or information constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or otherwise caused or contributed to a death, serious injury, or serious illness. Such an entity need not admit, and may deny, that the report or information submitted by the entity constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or caused or contributed to a death, serious injury, or serious illness.

''(7) To carry out this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 and 2012.''.

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall establish and begin implementation of the registry under section 519(g) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), by not later than the date that is 36 months after the date of the enactment of this Act, without regard to whether or not final regulations to establish and operate the registry have been promulgated by such date.

(3) CONFORMING AMENDMENT.—Section 303(f)(1)(B)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333(f)(1)(B)(ii)) is amended by striking ''519(g)'' and inserting ''519(h)''.

(b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDENTIFIERS.—

(1) RECOMMENDATIONS.—The HIT Policy Committee established under section 3002 of the Public Health Service Act (42 U.S.C. 300jj–12) shall recommend to the head of the Office of the National Coordinator for Health Information Technology standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device (as defined under section 519(g)(1)(B) of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a)).

(2) STANDARDS, IMPLEMENTATION CRITERIA, AND CERTIFICATION CRITERIA.—The Secretary of Health and Human Services, acting through the head of the Office of the National Coordinator for Health Information Technology, shall adopt standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device referred to in paragraph (1), if such an identifier is required by section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) for the device.

(c) UNIQUE DEVICE IDENTIFICATION SYSTEM.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall issue proposed regulations to implement section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) not later than 6 months after the date of the enactment of this Act.

SEC. 2572. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS AND OF ARTICLES OF FOOD SOLD FROM VENDING MACHINES.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subclause (i), by inserting ''except as provided in clause (H)(ii)(III),'' after ''(i)'' ; and

(2) in subclause (ii), by inserting ''except as provided in clause (H)(ii)(III),'' after ''(ii)''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Clause (C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—In the case of an article of food sold from a vending machine that—

''(I) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(II) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the

name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of the enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of the enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''.

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343–1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under section 403A(a)(4) of such Act;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 2573. PROTECTING CONSUMER ACCESS TO GENERIC DRUGS.

(a) FINDINGS; PURPOSE.—

(1) FINDINGS.—The Congress finds the following:

(A) In 1984, the Drug Price Competition and Patent Term Restoration Act (Pub. L. 98–417; in this subsection referred to as the ''1984 Act'') was enacted with the intent of facilitating the early entry of generic drugs while preserving incentives for innovation.

(B) Prescription drugs make up 10 percent of national health care spending, but for the past decade have been one of the fastest growing segments of health care expenditures.

(C) Until recently, the 1984 Act was successful in facilitating generic competition to the benefit of consumers and health care payers—although 67 percent of all prescriptions dispensed in the United States are generic drugs, they account for only 20 percent of all expenditures.

(D) In recent years, the intent of the 1984 Act has been subverted by certain settlement agreements between brand companies and their potential generic competitors that make reverse payments, i.e., payments by the brand company to the generic company.

(E) These settlement agreements have unduly delayed the marketing of low-cost generic drugs contrary to free competition and the interests of consumers.

(F) The state of antitrust law relating to such settlement agreements is unsettled.

(2) PURPOSE.—The purpose of this section is to provide an additional means to effectuate the intent of the 1984 Act by enhancing competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs.

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

''(w) PROTECTING CONSUMER ACCESS TO GENERIC DRUGS.—

''(1) UNFAIR AND DECEPTIVE ACTS AND PRACTICES RELATED TO NEW DRUG APPLICATIONS.—

''(A) CONDUCT PROHIBITED.—It shall be unlawful for any person to directly or indirectly be a party to any agreement resolving or settling a patent infringement claim in which—

''(i) an ANDA filer receives anything of value; and

''(ii) the ANDA filer agrees to limit or forego research, development, manufacturing, marketing, or sales, for any period of time, of the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim.

''(B) EXCEPTIONS.—Notwithstanding subparagraph (A)(i), subparagraph (A) does not prohibit a resolution or settlement of a patent infringement claim in which the value received by the ANDA filer includes no more than—

''(i) the right to market the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim, before the expiration of—

''(I) the patent that is the basis for the patent infringement claim; or

''(II) any other statutory exclusivity that would prevent the marketing of such drug; and

''(ii) the waiver of a patent infringement claim for damages based on prior marketing of such drug.

''(C) ENFORCEMENT.—

''(i) IN GENERAL.—A violation of subparagraph (A) shall be treated as an unfair and deceptive act or practice and an unfair method of competition in or affecting interstate commerce prohibited under section 5 of the Federal Trade Commission Act and shall be enforced by the Federal Trade Commission in the same manner, by the same means, and with the same jurisdiction as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this subsection.

''(ii) INAPPLICABILITY.—Subchapter A of chapter VII shall not apply with respect to this subsection.

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

''(i) AGREEMENT.—The term 'agreement' means anything that would constitute an agreement under section 5 of the Federal Trade Commission Act.

''(ii) AGREEMENT RESOLVING OR SETTLING.—The term 'agreement resolving or settling', in reference to a patent infringement claim, includes any agreement that is contingent upon, provides a contingent condition for, or is otherwise related to the resolution or settlement of the claim.

''(iii) ANDA.—The term 'ANDA' means an abbreviated new drug application for the approval of a new drug under section (j).

''(iv) ANDA FILER.—The term 'ANDA filer' means a party that has filed an ANDA with the Food and Drug Administration.

''(v) PATENT INFRINGEMENT.—The term 'patent infringement' means infringement of any patent or of any filed patent application, extension, reissuance, renewal, division, continuation, continuation in part, reexamination, patent term restoration, patent of addition, or extension thereof.

''(vi) PATENT INFRINGEMENT CLAIM.—The term 'patent infringement claim' means any allegation made to an ANDA filer, whether or not included in a complaint filed with a court of law, that its ANDA or drug to be manufactured under such ANDA may infringe any patent.

''(2) FTC RULEMAKING.—The Federal Trade Commission may, by rule promulgated under section 553 of title 5, United States Code, exempt certain agreements described in paragraph (1) from the requirements of this subsection if the Commission finds such agreements to be in furtherance of market competition and for the benefit of consumers. Consistent with the authority of the Commission, such rules may include interpretive rules and general statements of policy with respect to the practices prohibited under paragraph (1).''.

(c) NOTICE AND CERTIFICATION OF AGREEMENTS.—

(1) NOTICE OF ALL AGREEMENTS.—Section 1112(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 3155 note) is amended by—

(A) striking ''the Commission the'' and inserting the following: ''the Commission—

''(A) the'';

(B) striking the period at the end and inserting ''; and''; and

(C) adding at the end the following:

''(B) any other agreement the parties enter into within 30 days of entering into an agreement covered by subsection (a) or (b).''.

(2) CERTIFICATION OF AGREEMENTS.—Section 1112 of such Act is amended by adding at the end the following:

''(d) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under subsection (a), (b), or (c) shall execute and file with the Assistant Attorney General and the Commission a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 1112 of subtitle B of title XI of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, with

respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to subsection (a) or (b) of such section 1112 and have not been reduced to writing.''.

(d) GAO STUDY.—

(1) STUDY.—Beginning 2 years after the date of enactment of this Act, and each year for a period of 4 years thereafter, the Comptroller General shall conduct a study on the litigation in United States courts during the period beginning 5 years prior to the date of enactment of this Act relating to patent infringement claims involving generic drugs, the number of patent challenges initiated by manufacturers of generic drugs, and the number of settlements of such litigation. The Comptroller General shall transmit to Congress a report of the findings of such a study and an analysis of the effect of the amendments made by subsections (b) and (c) on such litigation, whether such amendments have had an effect on the number and frequency of claims settled, and whether such amendments resulted in earlier or delayed entry of generic drugs to market, including whether any harm or benefit to consumers has resulted.

(2) DISCLOSURE OF AGREEMENTS.—Notwithstanding any other law, agreements filed under section 1112 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 355 note), or unaggregated information from such agreements, shall be disclosed to the Comptroller General for purposes of the study under paragraph (1) within 30 days of a request by the Comptroller General.

PART 2—BIOSIMILARS

SEC. 2575. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

''(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

''(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) PEDIATRIC STUDIES.—

''(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

''(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

''(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(9) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

''(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

''(1) DEFINITIONS.—For the purposes of this subsection, the term—

''(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

''(B) 'relevant patent' means a patent that—

''(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

''(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

''(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

''(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

''(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

''(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

''(A) the reference product identified in the application; and

''(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

''(4) EXCHANGES CONCERNING PATENTS.—

''(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

''(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

''(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

''(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

''(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

''(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

''(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

''(iv) If the interested third party is issued or acquires an interest in a relevant patent

after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

''(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

''(ii) may specify whether the relevant patent is available for licensing; and

''(iii) shall specify the number and date of expiration of the relevant patent.

''(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

''(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

''(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

''(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product in a treatment indicated in the application, would not infringe the patent; or

''(II) the patent is invalid or unenforceable.

''(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

''(6) NOTIFICATION OF AGREEMENTS.—

''(A) REQUIREMENTS.—

''(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

''(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

''(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

''(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of—

''(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

''(II) the reference product;

''(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

''(iii) excludes any agreement that solely concerns—

''(I) purchase orders for raw material supplies;

''(II) equipment and facility contracts;

''(III) employment or consulting contracts; or

''(IV) packaging and labeling contracts.

''(C) FILING.—

''(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

''(I) 10 business days after the date on which the agreement is executed; and

''(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of an application described in such subparagraph.

''(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

''(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

''(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

''(E) ENFORCEMENT.—

''(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

''(I) brought by the United States; or

''(II) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

''(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

''(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

''(i) may define the terms used in this paragraph;

''(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

''(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

''(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 2576. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting '', including licensure of a biological product under section 351(k) of such Act'' before the period at the end.

SEC. 2577. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking ''or'' after ''patent,'';

(2) in subparagraph (B), by adding ''or'' after the comma at the end;

(3) by inserting the following after subparagraph (B):

''(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,''; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: '', or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent''.

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

Subtitle D—Community Living Assistance Services and Supports

SEC. 2581. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT (CLASS PROGRAM).

(a) ESTABLISHMENT OF CLASS PROGRAM.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 2301, is amended by adding at the end the following:

''TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

''SEC. 3201. PURPOSE.

''The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

''(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

''(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

''(3) alleviate burdens on family caregivers; and

''(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

''SEC. 3202. DEFINITIONS.

''In this title:

''(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

''(2) ACTIVELY EMPLOYED.—The term 'actively employed' means an individual who—

''(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

''(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

''(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' has the meaning given the term in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986.

''(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

''(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity designated by the Secretary under section 3205(a)(2)(A)(i).

''(6) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

''(i) has paid premiums for enrollment in such program for at least 60 months;

''(ii) has earned, for each calendar year that occurs during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for that year; and

''(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

''(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

''(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

''(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms 'hospital', 'nursing facility', 'intermediate care facility for the mentally retarded', and 'institution for mental diseases' have the meanings given such terms for purposes of Medicaid.

''(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term 'CLASS Independence Advisory Council' or 'Council' means the Advisory Council established under section 3207 to advise the Secretary.

''(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term 'CLASS Independence Benefit Plan' means the benefit plan developed and designated by the Secretary in accordance with section 3203.

''(10) CLASS INDEPENDENCE FUND.—The term 'CLASS Independence Fund' or 'Fund' means the fund established under section 3206.

''(11) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act.

''(12) PROTECTION AND ADVOCACY SYSTEM.—The term 'Protection and Advocacy System' means the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

''SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

''(a) PROCESS FOR DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

''(A) PREMIUMS.—Beginning with the first year of the CLASS program, and for each year thereafter, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

''(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

''(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

''(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

''(ii) The individual requires substantial supervision to protect the individual from

threats to health and safety due to substantial cognitive impairment.

''(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

''(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

''(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

''(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

''(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

''(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

''(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

''(A) evaluate the alternative benefit plans developed under paragraph (1); and

''(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

''(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

''(b) ADDITIONAL PREMIUM REQUIREMENTS.—

''(1) ADJUSTMENT OF PREMIUMS.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

''(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

''(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary.

''(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

''(I) has attained age 65;

''(II) has paid premiums for enrollment in the program for at least 20 years; and

''(III) is not actively employed.

''(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

''(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

''(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

''(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

''(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

''(D) PENALTY FOR REENROLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

''(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenrollment is effective; or

''(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

''(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program, the Secretary may factor in costs for administering the program, not to exceed—

''(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during each such year; and

''(B) in the case of subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

''(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with paragraph (2)) shall be used to—

''(A) determine the monthly premium for enrollment in the CLASS program; or

''(B) prevent an individual from enrolling in the program.

''SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

''(a) AUTOMATIC ENROLLMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall establish procedures under which each individual described in subsection (c) shall be automatically enrolled in the CLASS program by an employer of such individual under rules similar to the rules of sections 401(k)(13) and 414(w) of the Internal Revenue Code of 1986.

''(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

''(A) who is self-employed;

''(B) who has more than 1 employer;

''(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary; or

''(D) who is a spouse described in subsection (c)(2) of who is not subject to automatic enrollment.

''(3) ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary shall, by regulation, establish procedures to—

''(i) ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer; and

''(ii) allow for an individual's employer to deduct a premium for a spouse described in subsection (c)(1)(B) who is not subject to automatic enrollment.

''(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

''(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary shall prescribe.

''(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is—

''(1) an individual—

''(A) who has attained age 18;

''(B) who receives wages on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986;

''(C) who is actively employed; and

''(D) who is not—

''(i) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

''(ii) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act; or

''(2) the spouse of an individual described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

''(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

''(e) PAYMENT.—

''(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages of such individual in accordance with such procedures as the Secretary shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

''(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A).

''(f) TRANSFER OF PREMIUMS COLLECTED.—

''(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

''(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of

the amounts collected in accordance with this section. Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

''(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary shall establish procedures under which—

''(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretary shall establish, only during an open enrollment period established by the Secretary that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

''(2) an individual shall only be permitted to disenroll from the program during an annual disenrollment period established by the Secretary and in such form and manner as the Secretary shall establish.

''SEC. 3205. BENEFITS.

''(a) DETERMINATION OF ELIGIBILITY.—

''(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

''(2) ELIGIBILITY ASSESSMENTS.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

''(i) designate an entity (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to serve as an Eligibility Assessment System by providing for eligibility assessments of active enrollees who apply for receipt of benefits;

''(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

''(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

''(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an applicant is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

''(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

''(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

''(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

''(iii) is in the process of, or about to being the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

''(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

''(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

''(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

''(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

''(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

''(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

''(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

''(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advise and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(2).

''(c) PAYMENT OF BENEFITS.—

''(1) LIFE INDEPENDENCE ACCOUNT.—

''(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

''(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision-making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

''(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

''(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

''(ii) allowing the beneficiary to access such account through debit cards; and

''(iii) accounting for withdrawals by the beneficiary from such account.

''(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

''(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

''(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

''(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act, or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

''(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act or under a State plan amendment under subsection (i) of such section.

''(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

''(I) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

''(2) AUTHORIZED REPRESENTATIVES.—

''(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

''(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of

conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

''(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

''(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

''(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

''(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

''(i) the total amount of the accrued deferred benefits; or

''(ii) the applicable annual benefit.

''(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

''(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

''(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

''(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

''(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

''(I) the death of a beneficiary; or

''(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

''(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

''(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

''(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

''(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

''(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

''(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

''(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

''(A) information regarding how to access the appeals process established for the program;

''(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

''(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

''(2) ensure that the System and such counselors comply with the requirements of subsection (h).

''(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

''(1) accessing and coordinating long-term services and supports in the most integrated setting;

''(2) possible eligibility for other benefits and services;

''(3) development of a service and support plan;

''(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

''(5) available assistance with decision-making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

''(6) such other services as the Secretary, by regulation, may require.

''(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act, under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008.

''(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

''(h) PROTECTION AGAINST CONFLICTS OF INTEREST.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

''(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

''(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

''(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

''(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

''(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

''(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

''(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

''SEC. 3206. CLASS INDEPENDENCE FUND.

''(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

''(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

''(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

''(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

''(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act.

''(c) BOARD OF TRUSTEES.—

''(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

''(2) DUTIES.—

''(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

''(i) Hold the CLASS Independence Fund.

''(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

''(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the projections under section 3203(b)(1)(B)(i).

''(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

''(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

''(i) include—

''(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

''(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

''(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

''(IV) an actuarial opinion certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

''(ii) be printed as a House document of the session of the Congress to which the report is made.

''(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projections under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

''SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

''(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

''(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

''(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

''(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

''(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

''(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

''(1) the development of the CLASS Independence Benefit Plan under section 3203; and

''(2) the determination of monthly premiums under such plan.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act, other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

''SEC. 3208. REGULATIONS; ANNUAL REPORT.

''(a) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

''(b) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

''(1) The total number of enrollees in the program.

''(2) The total number of eligible beneficiaries during the fiscal year.

''(3) The total amount of cash benefits provided during the fiscal year.

''(4) A description of instances of fraud or abuse identified during the fiscal year.

''(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program or to prevent the occurrence of fraud or abuse.

''SEC. 3209. INSPECTOR GENERAL'S REPORT.

''The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

''(1) The eligibility determination process.

''(2) The provision of cash benefits.

''(3) Quality assurance and protection against waste, fraud, and abuse.

''(4) Recouping of unpaid and accrued benefits.''.

(b) CONFORMING AMENDMENTS TO MEDICAID.—For conforming provisions amending the Medicaid program, see section 1739.

Subtitle E—Miscellaneous

SEC. 2585. STATES FAILING TO ADHERE TO CERTAIN EMPLOYMENT OBLIGATIONS.

A State is eligible for Federal funds under the provisions of the Public Health Service Act (42 U.S.C. 201 et seq.) only if the State—

(1) agrees to be subject in its capacity as an employer to each obligation under division A of this Act and the amendments made by such division applicable to persons in their capacity as an employer; and

(2) assures that all political subdivisions in the State will do the same.

SEC. 2586. HEALTH CENTERS UNDER PUBLIC HEALTH SERVICE ACT; LIABILITY PROTECTIONS FOR VOLUNTEER PRACTITIONERS.

(a) IN GENERAL.—Section 224 (42 U.S.C. 233) is amended—

(1) in subsection (g)(1)(A)—

(A) in the first sentence, by striking ''or employee'' and inserting ''employee, or (subject to subsection (k)(4)) volunteer practitioner''; and

(B) in the second sentence, by inserting ''and subsection (k)(4)'' after ''subject to paragraph (5)''; and

(2) in each of subsections (g), (i), (j), (l), and (m), by striking the term ''employee, or contractor'' each place such term appears and inserting ''employee, volunteer practitioner, or contractor'';

(3) in subsection (g)(1)(H), by striking the term ''employee, and contractor'' each place such term appears and inserting ''employee, volunteer practitioner, and contractor'';

(4) in subsection (l), by striking the term ''employee, or any contractor'' and inserting ''employee, volunteer practitioner, or contractor''; and

(5) in subsections (h)(3) and (k), by striking the term ''employees, or contractors'' each place such term appears and inserting ''employees, volunteer practitioners, or contractors''.

(b) APPLICABILITY; DEFINITION.—Section 224(k) (42 U.S.C. 233(k)) is amended by adding at the end the following paragraph:

''(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

''(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

''(i) The practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.

''(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

''(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).''.

SEC. 2587. REPORT TO CONGRESS ON THE CURRENT STATE OF PARASITIC DISEASES THAT HAVE BEEN OVERLOOKED AMONG THE POOREST AMERICANS.

Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on the epidemiology of, impact of, and appropriate funding required to address

neglected diseases of poverty, including neglected parasitic diseases identified as Chagas disease, cysticercosis, toxocariasis, toxoplasmosis, trichomoniasis, the soil-transmitted helminths, and others. The report should provide the information necessary to enhance health policy to accurately evaluate and address the threat of these diseases.

SEC. 2588. OFFICE OF WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.''

''(e) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office on Women's Health (in the Department of Health and Human Services) is deemed to be a reference to the Office on Women's Health in the Office of the Secretary.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date;

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

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

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 927 and 928 as sections 928 and 929, respectively;

(2) by inserting after section 926 the following:

"SEC. 927. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and

other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''; and

(3) by adding at the end of section 928 (as redesignated by paragraph (1)) the following:

''(e) WOMEN'S HEALTH.—For the purpose of carrying out section 927 regarding women's health, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

''SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

''(d) DEFINITIONS.—For purposes of this section:

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter IX of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 911. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of its powers or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 2588A. OFFICES OF MINORITY HEALTH

(a) EXISTING OFFICE.—Section 1707(a) (42 U.S.C. 300u–6(a)) is amended by striking ''within the Office of Public Health and Science'' and inserting ''within the Office of the Secretary''.

(b) ADDITIONAL OFFICES.—Title XVII (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following:

''SEC. 1707A. ADDITIONAL OFFICES OF MINORITY HEALTH.

''(a) ESTABLISHMENT.—In addition to the Office of Minority Health established within the Office of the Secretary under section 1707, the Secretary shall establish an Office of Minority Health in each of the following agencies:

''(1) The Centers for Disease Control and Prevention.

''(2) The Substance Abuse and Mental Health Services Administration.

''(3) The Agency for Healthcare Research and Quality.

''(4) The Health Resources and Services Administration.

''(5) The Food and Drug Administration.

''(b) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established in an agency listed in subsection (a) shall be headed by a director, who shall be appointed by and report directly to the head of such agency.

''(c) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) is deemed to be a reference to the Office of Minority Health in the Office of the Secretary.''.

(c) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(d) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal appointive position with primary responsibility over minority health issues that is in existence in a office or agency of the Department of Health and Human Services on the date of enactment of this section shall not be terminated, reorganized, or have any of its powers or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

SEC. 2589. LONG-TERM CARE AND FAMILY CAREGIVER SUPPORT.

(a) AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965.—

(1) PROMOTION OF DIRECT CARE WORKFORCE.—Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by inserting before the semicolon the following: '', and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and of assisting States in developing a comprehensive State workforce development plan with respect to such workforce, including assisting efforts to systematically assess, track, and report on workforce adequacy and capacity''.

(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL.—Section 202 of such Act (42 U.S.C. 3012) is amended by adding at the end the following:

''(g)(1) Not later than 90 days after the date of the enactment of this subsection, the Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel to examine and formulate recommendations on—

''(A) working conditions and training for workers providing long-term services and supports, including home health aides, certified nurse aides, and personal care attendants; and

''(B) other workforce issues related to such workers, including with respect to the adequacy of the number of such workers; the salaries, wages, and benefits of such workers; and access to the services provided by such workers.

''(2) The Panel shall include representatives of—

''(A) relevant home- and community-based service providers, health care agencies, and facilities (including personal or home care agencies, home health care agencies, nursing homes, assisted living facilities, and residential care facilities);

''(B) the disability community, including individuals with disabilities and family caregivers;

''(C) the nursing community;

''(D) direct care workers (which may include unions and national organizations);

''(E) older individuals, including senior individuals and family caregivers;

''(F) State and Federal health care entities; and

''(G) experts in workforce development and adult learning.

''(3) Within one year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary and the Congress on workforce issues related to providing long-term services and supports, including information on core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources.

''(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 States to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

''(5) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.''.

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1965.—Section 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking '', $173,000,000'' and all that follows through ''2011'', and inserting ''and $250,000,000 for each of fiscal years 2011, 2012, and 2013''.

SEC. 2590. WEB SITE ON HEALTH CARE LABOR MARKET AND RELATED EDUCATIONAL AND TRAINING OPPORTUNITIES.

(a) IN GENERAL.—The Secretary of Labor, in consultation with the National Center for Health Workforce Analysis, shall establish and maintain a Web site to serve as a comprehensive source of information, searchable by workforce region, on the health care labor market and related educational and training opportunities.

(b) CONTENTS.—The Web site maintained under this section shall include the following:

(1) Information on the types of jobs that are currently or are projected to be in high demand in the health care field, including—

(A) salary information; and

(B) training requirements, such as requirements for educational credentials, licensure, or certification.

(2) Information on training and educational opportunities within each region for the type of jobs described in paragraph (1), including by—

(A) type of provider or program (such as public, private nonprofit, or private for-profit);

(B) duration;

(C) cost (such as tuition, fees, books, laboratory expenses, and other mandatory costs);

(D) performance outcomes (such as graduation rates, job placement, average salary, job retention, and wage progression);

(E) Federal financial aid participation;

(F) average graduate loan debt;

(G) student loan default rates;

(H) average institutional grant aid provided;

(I) Federal and State accreditation information; and

(J) other information determined by the Secretary.

(3) A mechanism for searching and comparing training and educational options for specific health care occupations to facilitate informed career and education choices.

(4) Financial aid information, including with respect to loan forgiveness, loan cancellation, loan repayment, stipends, scholarships, and grants or other assistance authorized by this Act or other Federal or State programs.

(c) PUBLIC ACCESSIBILITY.—The Web site maintained under this section shall—

(1) be publicly accessible;

(2) be user friendly and convey information in a manner that is easily understandable; and

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2591. ONLINE HEALTH WORKFORCE TRAINING PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

''(f) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

''(1) GRANT PROGRAM.—

''(A) IN GENERAL.—The Secretary in consultation with the Secretary of Health and Human Services, shall award National Health Workforce Online Training Grants on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grant with other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

''(B) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

''(i) an entity shall be an educational institution, community-based organization, nonprofit organization, workforce investment board, or local or county government; and

''(ii) an entity shall provide online workforce training for individuals seeking to attain or advance in health care occupations, including nursing, nursing assistants, dentistry, pharmacy, health care management and administration, public health, health information systems analysis, medical assistants, and other health care practitioner and support occupations.

''(C) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

''(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

''(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

''(iii) conduct training for occupations with national or local shortages.

''(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

''(i) the number of participants;

''(ii) the services received by the participants;

''(iii) program completion rates;

''(iv) factors determined as significantly interfering with program participation or completion;

''(v) the rate of job placement; and

''(vi) other information as determined as needed by the Secretary.

''(E) OUTREACH.—Grantees under this paragraph shall conduct outreach activities to disseminate information about their program and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

''(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be used to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected to be achieved by the grantee on the indicators of performance.

''(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $50,000,000 for fiscal years 2011 through 2020.

''(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.—

''(A) DESCRIPTION OF GRANT.—The Secretary may award one or more grants to eligible postsecondary educational institutions to provide the services described in this paragraph.

''(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

''(i) have demonstrated the ability to disseminate research on best practices for implementing workforce investment programs; and

''(ii) be a national leader in producing cutting-edge research on technology related to workforce investment systems under subtitle B.

''(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

''(i) to provide technical assistance to entities that receive grants under paragraph (1);

''(ii) to collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

''(iii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

''(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.''.

SEC. 2592. ACCESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

''SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 9 months after the date of enactment of the Affordable Health Care for America Act, the Architectural and Transportation Barriers Compliance Board (Access Board) shall issue guidelines setting forth the minimum technical criteria for new medical diagnostic equipment to be purchased for use in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that such equipment is accessible to, and usable by, individuals with disabilities, including provisions to ensure independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to new purchases of equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.

''(c) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

''(1) prescribe regulations in an accessible format as necessary to carry out the provisions of such Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

''(2) ensure that health care providers and health care plans covered by the Affordable Health Care for America Act meet the requirements of the Americans with Disabilities Act and section 504, including provisions ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

''(d) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board (Access Board) shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (c).''.

SEC. 2593. DUPLICATIVE GRANT PROGRAMS.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study to determine if any new division C grant program is duplicative of one or more other grant programs of the Department of Health and Human Services that—

(1) are specifically authorized in the Public Health Service Act (42 U.S.C. 201 et seq.); or

(2) are receiving appropriations.

(b) DUPLICATIVE PROGRAMS.—If the Secretary determines under subsection (a) that a new division C grant program is duplicative of one or more other grant programs described in such subsection, the Secretary shall—

(1) attempt to integrate the new division C grant program with the duplicative programs; and

(2) if the Secretary determines that such integration is not appropriate or has not been successful, promulgate a rule eliminating the duplication, including, if appropriate, by terminating one or more programs.

(c) CONTINUED AVAILABILITY OF FUNDS.—Any funds appropriated to carry out a program that is terminated under subsection (b)(2) shall remain available for obligation for the one or more programs that—

(1) were determined under subsection (a) to be duplicative of such program; and

(2) remain in effect.

(d) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to the Congress and make available to the public a report that contains the results of the study required under subsection (a).

(e) CONGRESSIONAL REVIEW.—Any rule under subsection (b)(2) terminating a program is deemed to be a major rule for purposes of chapter 8 of title 5, United States Code.

(f) DEFINITION.—In this section, the term ''new division C grant program''—

(1) means a grant program first established by this division; and

(2) excludes any program whose statutory authorization was in existence before the enactment of this division.

SEC. 2594. DIABETES SCREENING COLLABORATION AND OUTREACH PROGRAM.

(a) ESTABLISHMENT.—With respect to diabetes screening tests and for the purposes of reducing the number of undiagnosed seniors with diabetes or prediabetes, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall—

(1) review uptake and utilization of diabetes screening benefits, consistent with recommendations of the Task Force on Clinical Preventive Services (established under section 3131 of the Public Health Service Act, as added by section 2301 of this Act), to identify and address any existing problems, with regard to uptake and utilization and related data collection mechanisms; and

(2) establish an outreach program to identify existing efforts by agencies of the Department of Health and Human Services and by the private and nonprofit sectors to increase awareness among seniors and providers of diabetes screening benefits.

(b) CONSULTATION.—The Secretary shall carry out this section in consultation with—

(1) the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health; and

(2) entities with an interest in diabetes, including industry, voluntary health organizations, trade associations, and professional societies.

(c) REPORT.—The Secretary shall submit an annual report to the Congress on the activities carried out under this section.

SEC. 2595. IMPROVEMENT OF VITAL STATISTICS COLLECTION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(1) promote the education and training of physicians on the importance of birth and death certification data and how to properly complete these documents in accordance with State law, including the collection of such data for diabetes and other chronic diseases as appropriate;

(2) encourage State adoption of the latest standard revisions of birth and death certificates; and

(3) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(b) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this section, the Secretary may promote improvements to the collection of diabetes mortality data, including, as appropriate, the addition by States of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

SEC. 2596. NATIONAL HEALTH SERVICES CORPS DEMONSTRATION ON INCENTIVE PAYMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services may establish a demonstration program under which, in addition to the salary and benefits otherwise owed to a member of the National Health Services Corps, incentive payments are awarded to any such member who is assigned to a health professional shortage area with extreme need.

(b) REPORT.—The Secretary shall submit to the Congress an annual report on the demonstration program under subsection (a).

(c) DEFINITIONS.—In this section:

(1) The term ''health professional shortage area with extreme need'' means a health professional shortage area that—

(A) is described in section 333A(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254f–1(a)(1)(A));

(B) is described in section 333(a)(1)(D)(ii)(IV) of such Act (42 U.S.C. 254f(a)(1)(D)(ii)(IV)); and

(C) has high rates of untreated disease, including chronic conditions.

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

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

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

SEC. 3001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the ''Indian Health Care Improvement Act Amendments of 2009''.

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

TITLE I—AMENDMENTS TO INDIAN LAWS

SEC. 3101. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.

(a) IN GENERAL.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

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

''(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

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

''SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

''(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians the general population.

''(3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

''(4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

''(5) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

''SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to assure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians and Urban Indians to at least the levels set forth in the goals contained within the Health People 2010 or successor objectives;

''(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

''(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

''(6) to provide funding for programs and facilities operated by Indian Tribes, Tribal Organizations, and Urban Indian Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

''SEC. 4. DEFINITIONS.

''For purposes of this Act:

''(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

''(2) The term 'Area Office' means an administrative entity, including a program office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

''(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

''(4)(A) The term 'behavioral health' means the blending of substance (including alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

''(B) The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 805.

''(6) The term 'community college' means—

''(A) a tribal college or university, or

''(B) a junior or community college.

''(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

''(8) The term 'Department' means, unless otherwise designated, the Department of Health and Human Services.

''(9) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

''(A) controlling—

''(i) the development of diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

''(i) fluoridation of water; and

''(ii) immunizations.

''(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, naturopathic medicine, and any other health profession.

''(11) The term 'health promotion' means—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in conformity with physical and mental capacity;

''(D) making available safe water and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting culturally competent care; and

''(G) providing adequate and appropriate programs, which may include—

''(i) abuse prevention (mental and physical);

''(ii) community health;

''(iii) community safety;

''(iv) consumer health education;

''(v) diet and nutrition;

''(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

''(vii) environmental health;

''(viii) exercise and physical fitness;

''(ix) avoidance of fetal alcohol disorders;

''(x) first aid and CPR education;

''(xi) human growth and development;

''(xii) injury prevention and personal safety;

''(xiii) behavioral health;

''(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

''(xv) personal health and wellness practices;

''(xvi) personal capacity building;

''(xvii) prenatal, pregnancy, and infant care;

''(xviii) psychological well-being;

''(xix) reproductive health and family planning;

''(xx) safe and adequate water;

''(xxi) healthy work environments;

''(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

''(xxiii) stress control;

''(xxiv) substance abuse;

''(xxv) sanitary facilities;

''(xxvi) sudden infant death syndrome prevention;

''(xxvii) tobacco use cessation and reduction;

''(xxviii) violence prevention; and

''(xxix) activities to promote achievement of any of the objectives described in section 3(2).

''(12) The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 805, except that, for the purpose of sections 102 and 103, the term also means any individual who—

''(A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or

''(ii) is a descendant, in the first or second degree, of any such member;

''(B) is an Eskimo or Aleut or other Alaska Native;

''(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

''(D) is determined to be an Indian under regulations promulgated by the Secretary.

''(13) The term 'Indian Health Program' means—

''(A) any health program administered directly by the Service;

''(B) any Tribal Health Program; or

''(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').

''(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(15) The term 'junior or community college' has the meaning given the term by section 312(f) of the Higher Education Act of 1965 (20 U.S.C. 1058(f)).

''(16) The term 'reservation' means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

''(17) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

''(18) The term 'Service' means the Indian Health Service.

''(19) The term 'Service Area' means the geographical area served by each Area Office.

''(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

''(21) The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(22) The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients

and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(23) The term 'tribal college or university' has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

''(24) The term 'Tribal Health Program' means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(25) The term 'Tribal Organization' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(26) The term 'Urban Center' means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

''(27) The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

''(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

''(B) The individual is an Eskimo, Aleut, or other Alaska Native.

''(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

''(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

''(28) The term 'urban Indian organization' means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) provides for the participation of all interested Indian groups and individuals; and (D) is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

''TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

''SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and urban Indian organizations involved in the provision of health services to Indians.

''SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities, Tribal Health Programs, or urban Indian organizations to assist such entities in meeting the costs of—

''(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

''(A) to enroll in courses of study in such health professions; or

''(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

''(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

''(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) GRANTS.—

''(1) APPLICATION.—No grant may be made under this section unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give a preference to applications submitted by Tribal Health Programs or urban Indian organizations.

''(2) AMOUNT OF GRANTS; PAYMENT.—The amount of a grant under this section shall be determined by the Secretary. Payments pursuant to this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, grants shall be for 3 years, as provided in regulations issued pursuant to this Act.

''SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

''(a) SCHOLARSHIPS AUTHORIZED.—The Secretary, acting through the Service, shall provide scholarship grants to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

''(2) have demonstrated the potential to successfully complete courses of study in the health professions.

''(b) PURPOSES.—Scholarship grants provided pursuant to this section shall be for the following purposes:

''(1) Compensatory preprofessional education of any recipient, such scholarship not to exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued under this Act).

''(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years. An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.

''(c) OTHER CONDITIONS.—Scholarships under this section—

''(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

''(2) shall not be denied solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

''(3) shall not be denied solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

''SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

''(a) IN GENERAL.—

''(1) AUTHORITY.—The Secretary, acting through the Service, shall make scholarship grants to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Services Act (42 U.S.C. 254*l*), except as provided in subsection (b) of this section.

''(2) DETERMINATIONS BY SECRETARY.—The Secretary, acting through the Service, shall determine—

''(A) who shall receive scholarship grants under subsection (a); and

''(B) the distribution of the scholarships among health professions on the basis of the relative needs of Indians for additional service in the health professions.

''(3) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(b) ACTIVE DUTY SERVICE OBLIGATION.—

''(1) OBLIGATION MET.—The active duty service obligation under a written contract with the Secretary under this section that an Indian has entered into shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice equal to 1 year for each school year for which the participant receives a scholarship award under this part, or 2 years, whichever is greater, by service in 1 or more of the following:

''(A) In an Indian Health Program.

''(B) In a program assisted under title V of this Act.

''(C) In the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(D) In a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, the health service provided to Indians would not decrease.

''(2) OBLIGATION DEFERRED.—At the request of any individual who has entered into a contract referred to in paragraph (1) and who receives a health professions degree requiring postgraduate training for licensure or to improve clinical skills, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

''(A) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service under this subsection.

''(B) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

''(C) The active duty service obligation will be served in the health profession of that individual in a manner consistent with paragraph (1).

''(D) A recipient of a scholarship under this section may, at the election of the recipient, meet the active duty service obligation described in paragraph (1) by service in a program specified under that paragraph that—

''(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

''(ii) serves the Indian Tribe in which the recipient is enrolled.

''(3) PRIORITY WHEN MAKING ASSIGNMENTS.—Subject to paragraph (2), the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active

duty service obligation described in paragraph (1), shall give priority to assigning individuals to service in those programs specified in paragraph (1) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(c) PART-TIME STUDENTS.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

''(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the Secretary;

''(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

''(A) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the Secretary); or

''(B) 2 years; and

''(3) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254*l*(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

''(d) BREACH OF CONTRACT.—

''(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1) an individual breaches a written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) WAIVERS AND SUSPENSIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

''(A) it is not possible for the recipient to meet that obligation or make that payment;

''(B) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(C) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(5) EXTREME HARDSHIP.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

''(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

''SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

''(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

''(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

''(7) to the maximum extent feasible, employs qualified Indians in the program.

''(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian Health Program;

''(2) in a program assisted under title V of this Act; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

''SEC. 106. SCHOLARSHIP PROGRAMS FOR INDIAN TRIBES.

''(a) IN GENERAL.—

''(1) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

''(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

''(3) APPLICATION.—An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—A Tribal Health Program receiving a grant under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

''(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

''(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

''(B) 20 percent of such costs may be paid from any other source of funds.

''(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health professions contemplated by this Act.

''(d) CONTRACT.—

''(1) IN GENERAL.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship.

''(2) REQUIREMENTS.—Such contract shall—

''(A) obligate such recipient to provide service in an Indian Health Program or urban Indian organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

''(i) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

''(ii) such greater period of time as the recipient and the Tribal Health Program may agree;

''(B) provide that the amount of the scholarship—

''(i) may only be expended for—

''(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

''(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as

determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

''(ii) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

''(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

''(3) SERVICE IN OTHER SERVICE AREAS.—The contract may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located.

''(e) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level as determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

''(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

''(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

''(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

''(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

''SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

''(a) EMPLOYMENT PREFERENCE.—Any individual who receives a scholarship pursuant to section 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an urban Indian organization, or other agencies of the Department as available, during any nonacademic period of the year.

''(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted in determining fulfillment of the service obligation incurred as a condition of the scholarship.

''(c) TIMING; LENGTH OF EMPLOYMENT.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an urban Indian organization during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

''SEC. 108. CONTINUING EDUCATION ALLOWANCES.

''In order to encourage scholarship and stipend recipients under sections 104, 105, 106, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian Health Program and to provide their services in the rural and remote areas where a significant portion of Indians reside, the Secretary, acting through the Service, may—

''(1) provide programs or allowances to transition into an Indian Health Program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, 106, and 115; and

''(2) provide programs or allowances to health professionals employed in an Indian Health Program to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation, management, leadership, and refresher training courses.

''SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

''(1) provide for the training of Indians as community health representatives; and

''(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

''(b) DUTIES.—The Community Health Representative Program of the Service, shall—

''(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by the Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

''(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

''(4) maintain a system that provides close supervision of Community Health Representatives;

''(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

''(6) promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Service Loan Repayment Program (hereinafter referred to as the 'Loan Repayment Program') in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and urban Indian organizations.

''(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

''(1)(A) be enrolled—

''(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254*l*–1(b)(1)(c)(i))) and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

''(ii) in an approved graduate training program in a health profession; or

''(B) have—

''(i) a degree in a health profession; and

''(ii) a license to practice a health profession;

''(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

''(B) meet the professional standards for civil service employment in the Service; or

''(C) be employed in an Indian Health Program or urban Indian organization without a service obligation; and

''(3) submit to the Secretary an application for a contract described in subsection (e).

''(c) APPLICATION.—

''(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make a decision on an informed basis.

''(2) CLEAR LANGUAGE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

''(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) PRIORITIES.—

''(1) LIST.—Consistent with subsection (j), the Secretary shall annually—

''(A) identify the positions in each Indian Health Program or urban Indian organization for which there is a need or a vacancy; and

''(B) rank those positions in order of priority.

''(2) APPROVALS.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

''(A) give first priority to applications made by individual Indians; and

''(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

''(i) individuals recruited through the efforts of an Indian Health Program or urban Indian organization; and

''(ii) other individuals based on the priority rankings under paragraph (1).

''(e) RECIPIENT CONTRACTS.—

''(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

''(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (C), the Secretary agrees—

''(I) to pay loans on behalf of the individual in accordance with the provisions of this section; and

''(II) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a Tribal Health Program or urban Indian organization as provided in clause (ii)(III); and

''(ii) subject to subparagraph (C), the individual agrees—

''(I) to accept loan payments on behalf of the individual;

''(II) in the case of an individual described in subsection (b)(1)—

''(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

''(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

''(III) to serve for a time period (in this section referred to as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian Health Program or urban Indian organization to which the individual may be assigned by the Secretary;

''(B) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under subparagraph (A)(ii)(III);

''(C) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

''(D) a statement of the damages to which the United States is entitled under subsection (k) for the individual's breach of the contract; and

''(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

''(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

''(2) the Secretary's disapproving an individual's participation in such Program.

''(g) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT.—For each year of obligated service that an individual contracts to serve under subsection (e), the Secretary may pay up to $35,000 or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act, whichever is more, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

''(A) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

''(B) provides an incentive to serve in Indian Health Programs and urban Indian organizations with the greatest shortages of health professionals; and

''(C) provides an incentive with respect to the health professional involved remaining in an Indian Health Program or urban Indian organization with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

''(3) TIMING.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(4) REIMBURSEMENTS FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual, the Secretary—

''(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

''(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

''(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

''(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

''(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

''(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall—

''(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

''(2) give priority to assigning individuals to Indian Health Programs and urban Indian organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(l) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual—

''(A) is enrolled in the final year of a course of study and—

''(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) voluntarily terminates such enrollment; or

''(iii) is dismissed from such educational institution before completion of such course of study; or

''(B) is enrolled in a graduate training program and fails to complete such training program.

''(2) OTHER BREACHES; FORMULA FOR AMOUNT OWED.—If, for any reason not specified in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (e)(2), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: $A=3Z(t-s/t)$ in which—

''(A) 'A' is the amount the United States is entitled to recover;

''(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury;

''(C) 't' is the total number of months in the individual's period of obligated service; and

''(D) 's' is the number of months of such period served by such individual in accordance with this section.

''(3) TIME PERIOD FOR REPAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

''(4) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

''(5) RECOVERY OF DELINQUENCY.—

''(A) IN GENERAL.—If damages described in paragraph (4) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

''(i) use collection agencies contracted with by the Administrator of General Services; or

''(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

''(B) REPORT.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

''(m) WAIVER OR SUSPENSION OF OBLIGATION.—

''(1) IN GENERAL.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

''(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

''(3) HARDSHIP WAIVER.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

''(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

''(n) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to Congress under section 801, a report concerning the previous fiscal year which sets forth by Service Area the following:

''(1) A list of the health professional positions maintained by Indian Health Programs and urban Indian organizations for which recruitment or retention is difficult.

''(2) The number of Loan Repayment Program applications filed with respect to each type of health profession.

''(3) The number of contracts described in subsection (e) that are entered into with respect to each health profession.

''(4) The amount of loan payments made under this section, in total and by health profession.

''(5) The number of scholarships that are provided under sections 104 and 106 with respect to each health profession.

''(6) The amount of scholarship grants provided under sections 104 and 106, in total and by health profession.

''(7) The number of providers of health care that will be needed by Indian Health Programs and urban Indian organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.

''(8) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or urban Indian organizations for which recruitment or retention is difficult.

"SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

''(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the 'LRRF'). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

''(b) USE OF FUNDS.—

''(1) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

''(A) to which a scholarship recipient under section 104 and 106 or a loan repayment program participant under section 110 has been assigned to meet the obligated service requirements pursuant to such sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104, 106, or 110.

''(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or recruit and employ, directly or by contract, health professionals to provide health care services.

''(c) INVESTMENT OF FUNDS.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary of Health and Human Services determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(d) SALE OF OBLIGATIONS.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

"SEC. 112. RECRUITMENT ACTIVITIES.

''(a) REIMBURSEMENT FOR TRAVEL.—The Secretary, acting through the Service, may reimburse health professionals seeking positions with Indian Health Programs or urban Indian organizations, including individuals considering entering into a contract under section 110 and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

''(b) RECRUITMENT PERSONNEL.—The Secretary, acting through the Service, shall assign 1 individual in each Area Office to be responsible on a full-time basis for recruitment activities.

"SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall fund, on a competitive basis, innovative demonstration projects for a period not to exceed 3 years to enable Indian Health Programs and urban Indian organizations to recruit, place, and retain health professionals to meet their staffing needs.

''(b) ELIGIBLE ENTITIES; APPLICATION.—Any Indian Health Program or Urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

''(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian Health Program or urban Indian organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from Tribal

Health Programs and urban Indian organizations shall be given an equal opportunity to participate in the program under subsection (a).

"SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

''(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

''(1) Public or private schools of nursing.

''(2) Tribal colleges or universities.

''(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

''(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for 1 or more of the following:

''(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

''(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

''(3) To provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians.

''(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

''(5) To provide any program that is designed to achieve the purpose described in subsection (a).

''(c) APPLICATIONS.—Each application for a grant under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

''(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

''(1) Programs that provide a preference to Indians.

''(2) Programs that train nurse midwives or advanced practice nurses.

''(3) Programs that are interdisciplinary.

''(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

''(5) Programs conducted by tribal colleges and universities.

''(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide 1 of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

''(f) ACTIVE DUTY SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded by a grant provided under subsection (a). Such obligation shall be met by service—

''(1) in the Service;

''(2) in a program of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) (including programs under agreements with the Bureau of Indian Affairs);

''(3) in a program assisted under title V of this Act;

''(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health shortage area and addresses the health care needs of a substantial number of Indians; or

''(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

"SEC. 116. TRIBAL CULTURAL ORIENTATION.

''(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.

''(b) PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

''(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and urban Indian organizations;

''(2) be carried out through tribal colleges or universities;

''(3) include instruction in American Indian studies; and

''(4) describe the use and place of traditional health care practices of the Indian Tribes in the Service Area.

"SEC. 117. INMED PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Indian health careers recruitment program known as the 'Indians Into Medicine Program' (hereinafter in this section referred to as 'INMED') as a means of encouraging Indians to enter the health professions.

''(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide 1 of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

''(c) REGULATIONS.—The Secretary, pursuant to this Act, shall develop regulations to govern grants pursuant to this section.

''(d) REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program which—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary and secondary schools and community colleges located on reservations which will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the Indian Tribes and Indian communities which will be served by the program;

''(3) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

''(4) provides tutoring, counseling, and support to students who are enrolled in a health career program of study at the respective college or university; and

''(5) to the maximum extent feasible, employs qualified Indians in the program.

"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

''(a) GRANTS TO ESTABLISH PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such community colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program.

''(2) AMOUNT OF GRANTS.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

''(b) GRANTS FOR MAINTENANCE AND RECRUITING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

''(2) REQUIREMENTS.—Grants may only be made under this section to a community college which—

''(A) is accredited;

''(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

''(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

''(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs that train health professionals; and

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

''(D) has a qualified staff which has the appropriate certifications;

''(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs; and

''(2) providing technical assistance and support to such colleges.

''(d) ADVANCED TRAINING.—

''(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

''(A) has already received a degree or diploma in such health profession; and

''(B) provides clinical services on or near a reservation or for an Indian Health Program.

''(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

''(e) PRIORITY.—Where the requirements of subsection (b) are met, grant award priority

shall be provided to tribal colleges and universities in Service Areas where they exist.

"SEC. 119. RETENTION BONUS.

''(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, an Indian Health Program or urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

''(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

''(2) the Secretary determines is needed by Indian Health Programs and urban Indian organizations;

''(3) has—

''(A) completed 2 years of employment with an Indian Health Program or urban Indian organization; or

''(B) completed any service obligations incurred as a requirement of—

''(i) any Federal scholarship program; or

''(ii) any Federal education loan repayment program; and

''(4) enters into an agreement with an Indian Health Program or urban Indian organization for continued employment for a period of not less than 1 year.

''(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

''(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(1)(2)(B).

''(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

''(1) a position for which recruitment or retention is difficult; and

''(2) necessary for providing health care services to Indians.

"SEC. 120. NURSING RESIDENCY PROGRAM.

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or urban Indian organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study in an Indian Health Program or urban Indian organization leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor's degree (in the case of a registered nurse), or advanced degrees or certifications in nursing and public health.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to 1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicians), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses), participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified subsection (d)(1) of Section 104 for individuals failing to graduate from their degree program and subsection (l) of Section 110 for individuals failing to start or complete the obligated service.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.

''(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services; and

''(7) ensure that pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment, and further that dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, provided that uncomplicated extractions shall not be considered oral surgery under this section.

''(c) PROGRAM REVIEW.—

''(1) NEUTRAL PANEL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

''(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

''(2) STUDY.—

''(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

''(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

''(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

''(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

''(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

''(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

''(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska Tribal Organizations with respect to the adequacy and accuracy of the study.

''(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

''(A) any determination of the neutral panel under paragraph (2)(C); and

''(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

''(d) NATIONALIZATION OF PROGRAM.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

''(2) EXCEPTION.—The national Community Health Aide Program under paragraph (1) shall not include dental health aide therapist services.

''(3) REQUIREMENT.—In establishing a national program under paragraph (1), the Secretary shall not reduce the amount of funds provided for the Community Health Aide Program described in subsections (a) and (b).

"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

''The Secretary shall, by contract or otherwise, provide training for individuals in the administration and planning of Tribal Health Programs, with priority to Indians.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

''(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

"SEC. 124. NATIONAL HEALTH SERVICE CORPS.

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

''(1) remove a member of the National Health Service Corps from an Indian Health Program or urban Indian organization; or

''(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

''(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian Health Program, the services of a member of the National Health Service Corps assigned to an Indian Health Program may be limited to the persons who are eligible for services from such Program.

"SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

''(a) CONTRACTS AND GRANTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

''(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

''(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 3 years. Such contract or grant may be renewed for an additional 2-year period upon the approval of the Secretary.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

''(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

''(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

''(g) DEFINITION.—For the purposes of this section, the term 'educational curriculum' means 1 or more of the following:

''(1) Classroom education.

''(2) Clinical work experience.

''(3) Continuing education workshops.

"SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

''(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self-destructive behavior.

''(b) POSITIONS.—The positions referred to in subsection (a) are—

''(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(A) elementary and secondary education;

''(B) social services and family and child welfare;

''(C) law enforcement and judicial services; and

''(D) alcohol and substance abuse;

''(2) staff positions within the Service; and

''(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations (without regard to the funding source), and urban Indian organizations.

''(c) TRAINING CRITERIA.—

''(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or urban Indian organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

''(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or urban Indian organization, or assist the Indian Tribe, Tribal Organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(e) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').

"SEC. 127. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

''Employees of a Tribal Health Program or an Urban Indian Organization shall be exempt from payment of licensing, registration, and other fees imposed by a Federal agency to the same extent that Commissioned Corps Officers or other employees of the Indian Health Service are exempt from such fees.

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian Tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies:

''(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and improvement.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Indian Tribe, Tribal Organization, or Service Unit under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes and Tribal Organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in section 3(2) are not being achieved; and

''(B) the Indian Tribe or Tribal Organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian Tribe or Tribal Organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian Tribe or Tribal Organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining Tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian Tribe served by the Service or a Tribal Health Program;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian Tribes served by the Service or a Tribal Health Program; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service Unit, Indian Tribe, or Tribal Organization;

''(B) the number of Indians eligible for health services in each Service Unit or Indian Tribe or Tribal Organization; and

''(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian Tribes and Tribal Organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

''SEC. 202. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

''(a) FINDINGS.—Congress finds that health promotion and disease prevention activities—

''(1) improve the health and well-being of Indians; and

''(2) reduce the expenses for health care of Indians.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians to achieve the health status objectives set forth in section 3(2).

''(c) EVALUATION.—The Secretary, after obtaining input from the affected Tribal Health Programs, shall submit to the President for inclusion in the report which is required to be submitted to Congress under section 801 an evaluation of—

''(1) the health promotion and disease prevention needs of Indians;

''(2) the health promotion and disease prevention activities which would best meet such needs;

''(3) the internal capacity of the Service and Tribal Health Programs to meet such needs; and

''(4) the resources which would be required to enable the Service and Tribal Health Programs to undertake the health promotion and disease prevention activities necessary to meet such needs.

''SEC. 203. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

''(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service Unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian Tribes within that Service Unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.

''(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

''(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

''(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

''(B) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

''(2) DIABETES CONTROL OFFICERS.—

''(A) IN GENERAL.—The Secretary may establish and maintain in each Area Office a position of diabetes control officer to coordinate and manage any activity of that Area Office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

''(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

''SEC. 204. SHARED SERVICES FOR LONG-TERM CARE.

''(a) LONG-TERM CARE.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal Organization.

''(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

''(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

''SEC. 205. HEALTH SERVICES RESEARCH.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs.

''(b) COORDINATION OF RESOURCES AND ACTIVITIES.—The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.

''(c) AVAILABILITY.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

''(d) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

''(e) EVALUATION AND DISSEMINATION.—The Secretary shall periodically—

''(1) evaluate the impact of research conducted under this section; and

''(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

''SEC. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

''The Secretary, acting through the Service, shall provide for screening as follows:

''(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

''(2) Other cancer screening that receives an A or B rating as recommended by the United States Preventive Services Task Force established under section 915(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

''(A) frequency;

''(B) the population to be served;

''(C) the procedure or technology to be used;

''(D) evidence of effectiveness; and

''(E) other matters that the Secretary determines appropriate.

''SEC. 207. PATIENT TRAVEL COSTS.

''(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

''(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

''(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

''(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

''(b) PROVISION OF FUNDS.—The Secretary, acting through the Service, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

''(1) emergency air transportation and nonemergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

''SEC. 208. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT OF CENTERS.—The Secretary shall establish an epidemiology center in each Service Area to carry out the functions described in subsection (b). Any new center established after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian communities, each Service Area epidemiology center established under this section shall, with respect to such Service Area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian communities in the Service Area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

''(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian communities to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this section.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

''(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization is eligible to receive a grant under this subsection if—

''(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

''(B) the intertribal consortium is representative of the Indian Tribes or urban Indian communities in which the intertribal consortium is located.

''(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

''(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

''(C) demonstrate cooperation from Indian Tribes or Urban Indian Organizations in the area to be served.

''(5) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

''(A) to carry out the functions described in subsection (b);

''(B) to provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff on health care and health service management issues; and

''(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

''(e) ACCESS TO INFORMATION.—

''(1) An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996, as such entities are defined in part 164.501 of title 45, Code of Federal Regulations.

''(2) The Secretary shall grant to such epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

''(3) The activities of such an epidemiology center shall be for the purposes of research and for preventing and controlling disease, injury, or disability for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such activities are described in part 164.512 of title 45, Code of Federal Regulations (or a successor regulation).

''(f) FUNDS NOT DIVISIBLE.—An epidemiology center established under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for such center shall not be divisible.

''SEC. 209. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, is authorized to award grants to Indian Tribes and Tribal Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian children.

''(b) USE OF GRANT FUNDS.—A grant awarded under this section may be used for purposes which may include, but are not limited to, the following:

''(1) Developing health education materials both for regular school programs and after-school programs.

''(2) Training teachers in comprehensive school health education materials.

''(3) Integrating school-based, community-based, and other public and private health promotion efforts.

''(4) Encouraging healthy, tobacco-free school environments.

''(5) Coordinating school-based health programs with existing services and programs available in the community.

''(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

''(7) Developing behavioral health wellness programs.

''(8) Developing chronic disease prevention programs.

''(9) Developing substance abuse prevention programs.

''(10) Developing injury prevention and safety education programs.

''(11) Developing activities for the prevention and control of communicable diseases.

''(12) Developing community and environmental health education programs that include traditional health care practitioners.

''(13) Violence prevention.

''(14) Such other health issues as are appropriate.

''(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes and Tribal Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications for grants awarded under this section.

''(e) DEVELOPMENT OF PROGRAM FOR BIA-FUNDED SCHOOLS.—

''(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

''(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include—

''(A) school programs on nutrition education, personal health, oral health, and fitness;

''(B) behavioral health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

''(E) injury prevention and safety education programs; and

''(F) activities for the prevention and control of communicable diseases.

''(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

''(A) provide training to teachers in comprehensive school health education materials;

''(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

''(C) encourage healthy, tobacco-free school environments.

''SEC. 210. INDIAN YOUTH PROGRAM.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and administer a program to provide grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funds made available under this section may be used to—

''(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

''(B) develop and provide community training and education.

''(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(c).

''(c) DUTIES OF THE SECRETARY.—The Secretary shall—

''(1) disseminate to Indian Tribes, Tribal Organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

''(2) encourage the implementation of such models; and

''(3) at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance in the implementation of such models.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall establish criteria for the review and approval of applications or proposals under this section.

''SEC. 211. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian Tribes, Tribal Organizations, and urban Indian organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

''(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

''(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

''(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and urban Indian organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

''SEC. 212. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) FUNDING AUTHORIZED.—The Secretary may provide funding under this Act to meet the objectives set forth in section 3 of this Act through health care-related services and programs of the Service, Indian Tribes, and Tribal Organizations not otherwise described in this Act for the following services:

''(1) Hospice care.

''(2) Assisted living services.

''(3) Long-term care services.

''(4) Home- and community-based services.

''(b) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care under this section:

''(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

''(2) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

''(3) Such other individuals as an applicable Indian Health Program determines to be appropriate.

''(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

''(1) The term 'assisted living services' means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

''(A) shall not be required to obtain a license; but

''(B) shall meet all applicable standards for licensure.

''(2) The term 'home- and community-based services' means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

''(3) The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

''(4) The term 'long-term care services' has the meaning given the term 'qualified long-term care services' in section 7702B(c) of the Internal Revenue Code of 1986.

''(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

''SEC. 213. INDIAN WOMEN'S HEALTH CARE.

''The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

''SEC. 214. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

''(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned

Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

''(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

''(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

''(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

''(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

''(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

''(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include—

''(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

''(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

''(d) INTERGOVERNMENTAL TASK FORCE.—

''(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

''(A) The Secretary of Energy.

''(B) The Secretary of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(F) The Secretary of Health and Human Services.

''(G) The Director of the Indian Health Service.

''(2) DUTIES.—The Task Force shall—

''(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

''(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

''(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

''(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work-related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

''SEC. 215. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2025, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

''SEC. 216. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of North Dakota and South Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the designation of such States as a contract health service delivery area pursuant to subsection (a).

''SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.

''(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using an intertribal consortium as a contract care intermediary to improve the accessibility of health services to California Indians.

''(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the intertribal consortium to reimburse the intertribal consortium for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 805(a) throughout the California contract health services delivery area described in section 219 with respect to high cost contract care cases.

''(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the intertribal consortium under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the intertribal consortium during such fiscal year.

''(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

''(e) ADVISORY BOARD.—There is established an advisory board which shall advise the intertribal consortium in carrying out this section. The advisory board shall be composed of representatives, selected by the intertribal consortium, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least ½ of whom are not affiliated with the intertribal consortium.

''SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

''SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

''(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

''(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

''The Service shall provide funds for health care programs, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs, functions, services, activities, information technology, and facilities operated directly by the Service.

"SEC. 221. LICENSING.

''Licensed health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) while performing such services.

"SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

''With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

''(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

''(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

''(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 224(b), the provider shall have no further recourse against the patient who received the services.

"SEC. 225. OFFICE OF INDIAN MEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary may establish within the Service an office to be known as the 'Office of Indian Men's Health' (referred to in this section as the 'Office').

''(b) DIRECTOR.—

''(1) IN GENERAL.—The Office shall be headed by a director, to be appointed by the Secretary.

''(2) DUTIES.—The director shall coordinate and promote the status of the health of Indian men in the United States.

''(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the director of the Office, shall submit to Congress a report describing—

''(1) any activity carried out by the director as of the date on which the report is prepared; and

''(2) any finding of the director with respect to the health of Indian men.

"SEC. 226. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

''(A) Service Units; or

''(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

''(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other law.

''(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.

"SEC. 227. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

''(a) PREREQUISITES FOR EXPENDITURE OF FUNDS.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall—

''(1) consult with any Indian Tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

''(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the Medicare, Medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act by not later than 1 year after the date on which the construction or renovation of such facility is completed.

''(b) CLOSURES.—

''(1) EVALUATION REQUIRED.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress, not less than 1 year and not more than 2 years before the date of the proposed closure, an evaluation, completed not more than 2 years before such submission, of the impact of the proposed closure that specifies, in addition to other considerations—

''(A) the accessibility of alternative health care resources for the population served by such facility;

''(B) the cost-effectiveness of such closure;

''(C) the quality of health care to be provided to the population served by such facility after such closure;

''(D) the availability of contract health care funds to maintain existing levels of service;

''(E) the views of the Indian Tribes served by such facility concerning such closure;

''(F) the level of use of such facility by all eligible Indians; and

''(G) the distance between such facility and the nearest operating Service hospital.

''(2) EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a facility if such closure is necessary for medical, environmental, or construction safety reasons.

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

''(i) shall be developed in consultation with Indian Tribes and Tribal Organizations;

''(ii) shall give Indian Tribes' needs the highest priority;

''(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

''(II) shall include the methodology required in paragraph (2)(B)(v); and

''(III) may include such other facilities, and such renovation or expansion needs of any health care facility, as the Service, Indian Tribes, and Tribal Organizations may identify; and

''(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

''(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

''(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

''(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

''(i) was identified in the fiscal year 2008 Service budget justification as—

''(I) 1 of the 10 top-priority inpatient projects;

''(II) 1 of the 10 top-priority outpatient projects;

''(III) 1 of the 10 top-priority staff quarters developments; or

''(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

''(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

''(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

''(I) on the initiative of the Secretary; or

''(II) pursuant to a request of an Indian Tribe or Tribal Organization.

''(2) REPORT; CONTENTS.—

''(A) INITIAL COMPREHENSIVE REPORT.—

''(i) DEFINITIONS.—In this subparagraph:

''(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term 'Facilities Appropriation Advisory Board' means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Assistant Secretary—

''(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

''(bb) to address other facilities issues.

''(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term 'Facilities Needs Assessment Workgroup' means the workgroup established at the discretion of the Assistant Secretary—

''(aa) to review the health care facilities construction priority system; and

''(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

''(ii) INITIAL REPORT.—

''(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian Tribes, and Tribal Organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, staff quarters and hostels associated with health care facilities, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian Tribes, and Tribal Organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

''(II) INCLUSIONS.—The initial report shall include—

''(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

''(bb) such other information as the Secretary determines to be appropriate.

''(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

''(I) update the report under clause (ii) not less frequently that once every 5 years; and

''(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

''(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(i) A description of the health care facility priority system of the Service established under paragraph (1).

''(ii) Health care facilities lists, which may include—

''(I) the 10 top-priority inpatient health care facilities;

''(II) the 10 top-priority outpatient health care facilities;

''(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);

''(IV) the 10 top-priority staff quarters developments associated with health care facilities; and

''(V) the 10 top-priority hostels associated with health care facilities.

''(iii) The justification for such order of priority.

''(iv) The projected cost of such projects.

''(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

''(A) consult with and obtain information on all health care facilities needs from Indian Tribes, Tribal Organizations, and urban Indian organizations; and

''(B) review the total unmet needs of all Indian Tribes, Tribal Organizations, and urban Indian organizations for health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.

''(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

''(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

''(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

''(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

''(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

''(A) the Committees on Indian Affairs and Appropriations of the Senate;

''(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

''(C) the Secretary.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

''SEC. 302. SANITATION FACILITIES.

''(a) FINDINGS.—Congress finds the following:

''(1) The provision of sanitation facilities is primarily a health consideration and function.

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of sanitation facilities.

''(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

''(4) Many Indian homes and Indian communities still lack sanitation facilities.

''(5) It is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with sanitation facilities.

''(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the Secretary, acting through the Service, is authorized to provide the following:

''(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.

''(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the management of utility organizations which operate and maintain sanitation facilities.

''(3) Priority funding for operation and maintenance assistance for, and emergency repairs to, sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained

through the provision of sanitation facilities.

''(c) FUNDING.—Notwithstanding any other provision of law—

''(1) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.) to the Secretary of Health and Human Services;

''(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

''(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

''(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

''(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

''(7) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned, or appropriated whereby the Department's applicable policies, rules, and regulations shall apply in the implementation of such projects;

''(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act;

''(9) the Secretary of Health and Human Services shall, by regulation, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act; and

''(10) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Service from appropriate public authorities, nonprofit organizations or agencies, or Indian Tribes, as contributions by that authority, organization, agency, or tribe to agreements made under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), and such payments shall be credited to the same or subsequent appropriation account as funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

''(d) CERTAIN CAPABILITIES NOT PREREQUISITE.—The financial and technical capability of an Indian Tribe, Tribal Organization, or Indian community to safely operate, manage, and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(e) FINANCIAL ASSISTANCE.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (h)(1)(F).

''(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

''(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

''(1) any funds appropriated pursuant to this section; and

''(2) any funds appropriated for the purpose of providing sanitation facilities.

''(h) REPORT.—

''(1) REQUIRED; CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth—

''(A) the current Indian sanitation facility priority system of the Service;

''(B) the methodology for determining sanitation deficiencies and needs;

''(C) the criteria on which the deficiencies and needs will be evaluated;

''(D) the level of initial and final sanitation deficiency for each type of sanitation facility for each project of each Indian Tribe or Indian community;

''(E) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 et seq.), and to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (3)(A); and

''(F) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

''(2) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian Tribes and Indian communities.

''(3) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual, Indian Tribe, or Indian community sanitation facility to serve Indian homes are determined as follows:

''(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

''(i) complies with all applicable water supply, pollution control, and solid waste disposal laws; and

''(ii) deficiencies relate to routine replacement, repair, or maintenance needs.

''(B) A level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to—

''(i) small or minor capital improvements needed to bring the facility back into compliance;

''(ii) capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

''(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

''(C) A level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets 1 or more of the following conditions—

''(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

''(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or

''(iii) there is no access to or no approved or permitted solid waste facility available.

''(D) A level IV deficiency exists—

''(i) if a sanitation facility for an individual home, an Indian Tribe, or an Indian community exists but—

''(I) lacks—

''(aa) a safe water supply system; or

''(bb) a waste disposal system;

''(II) contains no piped water or sewer facilities; or

''(III) has become inoperable due to a major component failure; or

''(ii) if only a washeteria or central facility exists in the community.

''(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

''(i) DEFINITIONS.—For purposes of this section, the following terms apply:

''(1) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

''(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

''SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

''(a) BUY INDIAN ACT.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act'), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian Tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to regulations, that the project or function to be contracted for will not be satisfactory or such

project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

''(1) ownership and control by Indians;

''(2) equipment;

''(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

''(b) PAY RATES.—For the purposes of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

''(c) LABOR STANDARDS.—For the purposes of implementing the provisions of this title, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the 'Davis-Bacon Act').

''SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION.

''(a) IN GENERAL.—Notwithstanding any other provision of law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization by any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), including—

''(1) any plans or designs for such expansion, renovation, or modernization; and

''(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended.

''(b) PRIORITY LIST.—

''(1) IN GENERAL.—The Secretary shall maintain a separate priority list to address the needs for increased operating expenses, personnel, or equipment for such facilities. The methodology for establishing priorities shall be developed through regulations. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

''(c) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

''(1) the Indian Tribe or Tribal Organization—

''(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and

''(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel, or equipment; and

''(2) the expansion, renovation, or modernization—

''(A) is approved by the appropriate area director of the Service for Federal facilities; and

''(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

''(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements under subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information pursuant to regulations, including additional staffing, equipment, and other costs associated with the expansion.

''(e) CLOSURE OR CONVERSION OF FACILITIES.—If any Service facility which has been expanded, renovated, or modernized by an Indian Tribe or Tribal Organization under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

''SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

''(a) GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall make grants to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)). A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

''(2) GRANT AGREEMENT REQUIRED.—A grant under paragraph (1) may only be made available to a Tribal Health Program operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian Tribe or Tribal Organization).

''(b) USE OF GRANT FUNDS.—

''(1) ALLOWABLE USES.—A grant awarded under this section may be used for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 306; and

''(C) which, upon completion of such construction or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually no fewer than 150 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 806(c)(2); and

''(iii) provide ambulatory care in a Service Area (specified in the contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) with a population of no fewer than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 806(c)(2).

''(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

''(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—A grant provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C)(ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization applying for a grant under this section for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

''(c) GRANTS.—

''(1) APPLICATION.—No grant may be made under this section unless an application or proposal for the grant has been approved by the Secretary in accordance with applicable regulations and has set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out using a grant received under this section—

''(A) adequate financial support will be available for the provision of services at such facility;

''(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

''(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

''(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

''(A) a need for increased ambulatory care services; and

''(B) insufficient capacity to deliver such services.

''(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed pursuant to subsection (a)(1).

''(d) REVERSION OF FACILITIES.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, at any time after completion of the construction, expansion, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.

''(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or for reallocation or redesign thereunder.

''SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

''(a) HEALTH CARE DEMONSTRATION PROJECTS.—The Secretary, acting through

the Service, is authorized to make grants to, and enter into construction contracts or construction project agreements with, Indian Tribes or Tribal Organizations under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

''(1) waive any leasing prohibition;

''(2) permit carryover of funds appropriated for the provision of health care services;

''(3) permit the use of other available funds;

''(4) permit the use of funds or property donated from any source for project purposes;

''(5) provide for the reversion of donated real or personal property to the donor; and

''(6) permit the use of Service funds to match other funds, including Federal funds.

''(c) REGULATIONS.—The Secretary shall develop and promulgate regulations, not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, for the review and approval of applications submitted under this section.

''(d) CRITERIA.—The Secretary may approve projects that meet the following criteria:

''(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

''(2) A significant number of Indians, including those with low health status, will be served by the project.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The project is economically viable.

''(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

''(e) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

''(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

''(1) Cass Lake, Minnesota.

''(2) Mescalero, New Mexico.

''(3) Owyhee, Nevada.

''(4) Schurz, Nevada.

''(5) Ft. Yuma, California.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(h) SERVICE TO INELIGIBLE PERSONS.—Subject to section 806, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 806 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

''(i) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(j) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

''SEC. 307. LAND TRANSFER.

''Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

''SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

''The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j(l)) and regulations thereunder.

''SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

''(1) inpatient facilities;

''(2) outpatient facilities;

''(3) staff quarters;

''(4) hostels; and

''(5) specialized care facilities, such as behavioral health and elder care facilities.

''(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

''(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

''(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

''(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

''(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

''(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

''(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

''(7) whether, in the planning and design of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

''(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

''(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

''(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

''(c) REPORT.—Not later than September 30, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

''(1) the manner of consultation made as required by subsection (a); and

''(2) the results of the study, including any recommendations of the Secretary based on results of the study.

''SEC. 310. TRIBAL LEASING.

''A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

''SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

''(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project;

''(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project; or

''(3) in its application for a joint venture agreement, agrees—

''(A) to construct a facility for the joint venture which complies with the size and space criteria established by the Service; or

''(B) if the facility it proposes for the joint venture is already in existence or under construction, that only the portion of such facility which complies with the size and space criteria of the Service will be eligible for the joint venture agreement.

''(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

''(1) the Secretary first determines that the Indian Tribe or Tribal Organization has

the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

''(2) the Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, unless the Secretary determines, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of health care facilities.

''(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

''(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

''(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

''(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

''SEC. 312. LOCATION OF FACILITIES.

''(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any land allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

''(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

''(1) all lands within the exterior boundaries of any reservation; and

''(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation.

''SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

''(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

''(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the health care facility priority system under section 301(c).

''(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The Secretary shall consult with Indian Tribes and Tribal Organizations in determining the maximum renovation cost threshold.

''SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

''(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

''(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

''(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

''(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

''(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

''(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

''(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

''(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

''(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

''SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

''(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

''(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

''(c) DEFINITIONS.—For purposes of this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

''SEC. 316. OTHER FUNDING FOR FACILITIES.

''(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the

planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

''(c) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

''(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

''SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

''TITLE IV—ACCESS TO HEALTH SERVICES

''SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

''(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian Health Program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XXI of the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—

''(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service Unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service Unit makes collections, are entitled by reason of a provision of either such title.

''(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian Tribes being served by the Service Unit, be used for increasing the facility's capacity to provide, or improving the quality or accessibility of, services.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a Tribal Health Program upon the election of such Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such Program during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a Tribal Health Program may elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), but all amounts so reimbursed shall be used by the Tribal Health Program for the same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service may be used pursuant to subparagraph (B) of such subsection with respect to the Service.

''(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian Health Program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any Tribal Health Program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such Program receives such reimbursements or payments.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

''(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

''(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by Tribal Health Programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a Tribal Health Program or in the direct billing program established under this subsection if the Secretary determines that the Program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a Tribal Health Program with notice of a determination that the Program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the Program's participation in the direct billing program established under this subsection.

''(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.

''SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs on or near reservations, trust lands, and Alaska Native Villages, including programs to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

''(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act; and

''(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes or Tribal Organizations being served based on a schedule of income levels developed or implemented by such Tribe, Tribes, or Tribal Organizations).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

''(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to effect the purposes of this section.

''(d) FACILITATING COOPERATION IN ENROLLMENT AND RETENTION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall consult with States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and disseminate best practices with respect to facilitating agreements between the States and Indian Tribes, Tribal Organizations, and urban Indian organizations relating to enrollment and retention of Indians in programs established under titles XVIII, XIX, and XXI of the Social Security Act.

''(e) AGREEMENTS TO IMPROVE ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements between the Secretary and the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

''(f) DEFINITIONS.—In this section:

''(1) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(2) COST SHARING.—The term 'cost sharing' includes any deduction, deductible, copayment, coinsurance, or similar charge.

''(3) BENEFITS.—The term 'benefits' means, with respect to—

''(A) title XVIII of the Social Security Act, benefits under such title;

''(B) title XIX of such Act, medical assistance under such title; and

''(C) title XXI of such Act, assistance under such title.

''SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges incurred by the Secretary, an Indian Tribe, or Tribal Organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, in providing health services through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(3) RECOVERY FROM TORTFEASORS.—

''(A) IN GENERAL.—In any case in which an Indian Tribe or Tribal Organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian Tribe or Tribal Organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

''(B) TREATMENT.—The right of an Indian Tribe or Tribal Organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian Tribe or Tribal Organization.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

''(h) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with respect to populations served by such Indian Tribes and Tribal Organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and urban Indian organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws.

''SEC. 404. CREDITING OF REIMBURSEMENTS.

''(a) RETENTION OF AMOUNTS FOR USE BY PROGRAM.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 806 (relating to health services for ineligible persons), all reimbursements received or recovered, including under section 806, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an urban Indian organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

''(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

''SEC. 405. PURCHASING HEALTH CARE COVERAGE.

''(a) PURCHASING COVERAGE.—

''(1) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage that qualifies as creditable coverage under section 2701(c)(1) of the Public Health Service Act for such beneficiaries, including, subject to paragraph (2), through—

''(A) a tribally owned and operated health care plan;

''(B) a State or locally authorized or licensed health care plan;

''(C) a health insurance provider or managed care organization; or

''(D) a self-insured plan.

''(2) EXCEPTION.—The coverage provided under paragraph (1) may not include coverage consisting of—

''(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

''(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

''(3) PERMITTING PURCHASE OF COVERAGE BASED ON FINANCIAL NEED.—The purchase of coverage by an Indian Tribe, Tribal Organization, or urban Indian organization under this subsection may be based on the financial needs of beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

''(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

''SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

''SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

''(a) FINDINGS; PURPOSE.—

''(1) FINDINGS.—Congress finds that—

''(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

''(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

''(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIAN VETERAN.—The term 'eligible Indian veteran' means an Indian or Alaska Native veteran who receives any medical service that is—

''(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

''(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

''(2) LOCAL MEMORANDUM OF UNDERSTANDING.—The term 'local memorandum of understanding' means a memorandum of understanding between the Secretary (or a designee, including the director of any Area Office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

''(c) ELIGIBLE INDIAN VETERANS' EXPENSES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

''(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

''(d) TRIBAL APPROVAL OF MEMORANDA.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

''(e) FUNDING.—

''(1) TREATMENT.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not be considered to be Contract Health Service expenses.

''(2) USE OF FUNDS.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.

''SEC. 408. PAYOR OF LAST RESORT.

''Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

''SEC. 409. CONSULTATION.

''For provisions related to consultation with representatives of Indian Health Programs and urban Indian organizations with respect to the health care programs established under titles XVIII, XIX, and XXI of the Social Security Act, see section 1139(d) of the Social Security Act (42 U.S.C. 1320b–9(d)).

''SEC. 410. STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

''For provisions relating to—

''(1) outreach to families of Indian children likely to be eligible for child health assistance under the State children's health insurance program established under title XXI of the Social Security Act, see sections 2105(c)(2)(C) and 1139(a) of such Act (42 U.S.C. 1397ee(c)(2), 1320b–9); and

''(2) ensuring that child health assistance is provided under such program to targeted low-income children who are Indians and that payments are made under such program to Indian Health Programs and urban Indian organizations operating in the State that provide such assistance, see sections 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).

''SEC. 411. PREMIUM AND COST SHARING PROTECTIONS AND ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.

''For provisions relating to—

''(1) premiums or cost sharing protections for Indians furnished items or services directly by Indian Health Programs or through referral under the contract health service under the Medicaid program established under title XIX of the Social Security Act, see sections 1916(j) and 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o(j), 1396o–1(a)(1));

''(2) rules regarding the treatment of certain property for purposes of determining eligibility under such programs, see sections 1902(e)(13) and 2107(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(13), 1397gg(e)(1)(B)); and

''(3) the protection of certain property from estate recovery provisions under the Medicaid program, see section 1917(b)(3)(B) of such Act (42 U.S.C. 1396p(b)(3)(B)).

''SEC. 412. TREATMENT UNDER MEDICAID AND SCHIP MANAGED CARE.

''For provisions relating to the treatment of Indians enrolled in a managed care entity under the Medicaid program under title XIX of the Social Security Act and Indian Health Programs and urban Indian organizations that are providers of items or services to such Indian enrollees, see sections 1932(h) and 2107(e)(1)(H) of the Social Security Act (42 U.S.C. 1396u–2(h), 1397gg(e)(1)(H)).

''SEC. 413. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

''(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State Medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

''(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

''(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid

to the State of Arizona, New Mexico, or Utah;

''(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

''(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

''(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

''SEC. 414. EXCEPTION FOR EXCEPTED BENEFITS.

''The previous provisions of this title shall not apply to the provision of excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

''SEC. 415. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

''SEC. 501. PURPOSE.

''The purpose of this title is to establish and maintain programs in Urban Centers to make health services more accessible and available to Urban Indians.

''SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title. Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

''SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

''(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for Urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

''(1) estimate the population of Urban Indians residing in the Urban Center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

''(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

''(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

''(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

''(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Urban Indians; and

''(6) where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.

''(b) CRITERIA.—The Secretary, acting through the Service, shall, by regulation, prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of Urban Indians in the Urban Center or centers involved;

''(2) the size of the urban Indian population in the Urban Center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title, or under any current public health service project funded in a manner other than pursuant to this title;

''(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

''(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and

''(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

''(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health promotion and disease prevention services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under this section.

''(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) BEHAVIORAL HEALTH SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, behavioral health services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under subsection (a).

''(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the following:

''(A) The behavioral health needs of the urban Indian population concerned.

''(B) The behavioral health services and other related resources available to that population.

''(C) The barriers to obtaining those services and resources.

''(D) The needs that are unmet by such services and resources.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

''(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.

''(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) PREVENTION OF CHILD ABUSE.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians through grants to urban Indian organizations administering contracts entered into or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

''(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.

''(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims,

and to urban Indian perpetrators of child abuse (including sexual abuse).

''(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

''(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

''(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

''(C) the assessment required under paragraph (2).

''(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

''SEC. 504. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Indian Health Service or the General Services Administration for the purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d) to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

''(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation to the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically, to the urban Indian organization.

''(e) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply), an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be deemed to be an executive agency when carrying out such contract or grant.

''SEC. 505. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

''(a) GRANTS AND CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, may enter into contracts with or make grants to urban Indian organizations situated in Urban Centers for which contracts have not been entered into or grants have not been made under section 503.

''(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary has entered into a contract with, or made a grant to, under this section.

''(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the urban Indian organization successfully undertakes to—

''(A) document the health care status and unmet health care needs of urban Indians in the Urban Center involved; and

''(B) with respect to urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

''(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

''SEC. 506. EVALUATIONS; RENEWALS.

''(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and compliance with and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

''(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, the Secretary shall—

''(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

''(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

''(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the organization the areas of noncompliance or unsatisfactory performance and modify the contract or grant to prevent future occurrences of noncompliance or unsatisfactory performance. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew the contract or grant with the organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same Urban Center as the urban Indian organization whose contract or grant is not renewed under this section.

''(d) CONSIDERATIONS FOR RENEWALS.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and shall consider the results of the onsite evaluations or accreditations under subsection (b).

''SEC. 507. OTHER CONTRACT AND GRANT REQUIREMENTS.

''(a) PROCUREMENT.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections 1304 and 3131 through 3133 of title 40, United States Code.

''(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—

''(1) IN GENERAL.—Payments under any contracts or grants pursuant to this title, notwithstanding any term or condition of such contract or grant—

''(A) may be made in a single advance payment by the Secretary to the urban Indian organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such a single advance payment; and

''(B) if any portion thereof is unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

''(2) SEMIANNUAL AND QUARTERLY PAYMENTS AND REIMBURSEMENTS.—If the Secretary determines under paragraph (1)(A) that an urban Indian organization is not capable of administering an entire single advance payment, on request of the urban Indian organization, the payments may be made—

''(A) in semiannual or quarterly payments by not later than 30 days after the date on which the funding period with respect to which the payments apply begins; or

''(B) by way of reimbursement.

''(c) REVISION OR AMENDMENT OF CONTRACTS.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request and consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM SERVICES AND ASSISTANCE.—Contracts with or grants to urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

''SEC. 508. REPORTS AND RECORDS.

''(a) REPORTS.—

''(1) IN GENERAL.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, such urban Indian organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

''(A) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

''(B) Information on activities conducted by the organization pursuant to the contract or grant.

''(C) An accounting of the amounts and purpose for which Federal funds were expended.

''(D) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with urban Indian organizations.

''(2) HEALTH STATUS AND SERVICES.—

''(A) IN GENERAL.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall submit to Congress a report evaluating—

''(i) the health status of urban Indians;

''(ii) the services provided to Indians pursuant to this title; and

''(iii) areas of unmet needs in the delivery of health services to urban Indians.

''(B) CONSULTATION AND CONTRACTS.—In preparing the report under paragraph (1), the Secretary—

''(i) shall consult with urban Indian organizations; and

''(ii) may enter into a contract with a national organization representing urban Indian organizations to conduct any aspect of the report.

''(b) AUDIT.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COSTS OF AUDITS.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

''SEC. 509. LIMITATION ON CONTRACT AUTHORITY.

''The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

''SEC. 510. FACILITIES.

''(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

''(b) LOAN FUND STUDY.—The Secretary, acting through the Service, may carry out a study to determine the feasibility of establishing a loan fund to provide to urban Indian organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with section 309, including by submitting a report in accordance with subsection (c) of that section.

''SEC. 511. DIVISION OF URBAN INDIAN HEALTH.

''There is established within the Service a Division of Urban Indian Health, which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to urban Indian organizations.

''SEC. 512. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Urban Centers to those urban Indian organizations with which the Secretary has entered into a contract under this title or under section 201.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

''(1) The size of the urban Indian population.

''(2) Capability of the organization to adequately perform the activities required under the grant.

''(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. The standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.

''(4) Identification of the need for services.

''(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on the criteria established pursuant to subsection (c).

''(e) GRANTS SUBJECT TO CRITERIA.—Any grant received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

''SEC. 513. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service Units and Operating Units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''SEC. 514. URBAN NIAAA TRANSFERRED PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, through the Division of Urban Indian Health, shall make grants or enter into contracts with urban Indian organizations, to take effect not later than September 30, 2010, for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as 'NIAAA') and transferred to the Service.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

''SEC. 515. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service confers or conferences, to the greatest extent practicable, with Urban Indian Organizations.

''(b) DEFINITION OF CONFER; CONFERENCE.—In this section, the terms 'confer' and 'conference' mean an open and free exchange of information and opinions that—

''(1) leads to mutual understanding and comprehension; and

''(2) emphasizes trust, respect, and shared responsibility.

''SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

''(a) CONSTRUCTION AND OPERATION.—

''(1) IN GENERAL.—The Secretary, acting through the Service, through grant or contract, shall fund the construction and operation of at least 1 residential treatment center in each Service Area that meets the eligibility requirements set forth in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

''(2) TREATMENT.—Each residential treatment center described in paragraph (1) shall be in addition to any facilities constructed under section 707(b).

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible to obtain a facility under subsection (a)(1), a Service Area shall meet the following requirements:

''(1) There is an Urban Indian Organization in the Service Area.

''(2) There reside in the Service Area Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting.

''(3) There is a significant shortage of culturally competent residential treatment services for Urban Indian youth in the Service Area.

''SEC. 517. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) GRANTS AUTHORIZED.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among urban Indians.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

''(1) the size and location of the urban Indian population to be served;

''(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the urban Indian population to be served;

''(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

''(4) the capability of the organization to adequately perform the activities required under the grant; and

''(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 203(e)(1)(B) in the Area Office of the Service in which the organization is located.

''(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

''SEC. 518. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to urban Indians.

''SEC. 519. EFFECTIVE DATE.

''The amendments made by the Indian Health Care Improvement Act Amendments of 2009 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

''SEC. 520. ELIGIBILITY FOR SERVICES.

''Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

''SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

''(b) URBAN INDIAN ORGANIZATIONS.—The Secretary, acting through the Service, is authorized to establish programs, including programs for the awarding of grants, for urban Indian organizations that are identical to any programs established pursuant to section 126 (behavioral health training), section 209 (school health education), section 211 (prevention of communicable diseases), section 701 (behavioral health prevention and treatment services), and section 707(g) (multidrug abuse program).

''SEC. 522. HEALTH INFORMATION TECHNOLOGY.

''The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000(5) of the American Recovery and Reinvestment Act), telemedicine services development, and related infrastructure.

''TITLE VI—ORGANIZATIONAL IMPROVEMENTS

''SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2010, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 shall serve as Assistant Secretary.

''(4) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Assistant Secretary shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, carried out by or under the direction of the individual serving as Director of the Service on that day;

''(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

''(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(4) administer all scholarship and loan functions carried out under title I;

''(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

''(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

''(9) coordinate the activities of the Department concerning matters of Indian health; and

''(10) perform such other functions as the Secretary may designate.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

''(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

''SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish an automated management information system for the Service.

''(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

''(A) a financial management system;

''(B) a patient care information system for each area served by the Service;

''(C) privacy protections consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to privacy of automated management information systems of a Federal agency;

''(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area office of the Service;

''(E) an interface mechanism for patient billing and accounts receivable system; and

''(F) a training component.

''(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Tribal Health Program automated management information systems which—

''(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) ACCESS TO RECORDS.—The Service shall provide access of patients to their medical or health records which are held by, or on behalf of, the Service in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to access to health care records.

''(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

''SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this title.

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, urban Indian organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, urban Indian organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management; and

''(I) diagnostic services.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

''(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

''(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

''(C) identification and treatment of co-occurring disorders and comorbidity;

''(D) prevention of alcohol, drug, inhalant, and tobacco use;

''(E) early intervention, treatment, and aftercare;

''(F) promotion of healthy approaches to risk and safety issues; and

''(G) identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches for risk-related behavior;

''(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

''(F) sex specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including—

''(A) early intervention, treatment, and aftercare for affected families;

''(B) treatment for sexual assault and domestic violence; and

''(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches to managing conditions related to aging;

''(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

''(F) identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

''(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area,

and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

''(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

''(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Systems of Care, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

''(F) diagnostic services.

''(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian Tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

''SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the traditional health care practices of the Indian Tribes to be served.

''SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''(a) IN GENERAL.—Subject to the provisions of section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

''(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

''(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

''(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

''(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

''SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) GRANTS.—The Secretary, consistent with section 701, may make grants to Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used to—

''(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

''(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

''SEC. 707. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may incorporate Systems of Care, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian Tribe or Tribal Organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

''(1) the number of Indian youth who are being provided mental health services through the Service and Tribal Health Programs;

''(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and Tribal Health Programs;

''(3) the number of youth referred to the Service or Tribal Health Programs for mental health services;

''(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and Tribal Health Programs, reported separately for on- and off-reservation facilities; and

''(5) the costs of the services described in paragraph (4).

''SEC. 708. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

''(a) PURPOSE.—The purpose of this section is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention and treatment of Indian youth, including through—

''(1) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

''(2) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

''(3) training and related support for community leaders, family members and health and education workers who work with Indian youth;

''(4) the development of culturally relevant educational materials on suicide; and

''(5) data collection and reporting.

''(b) DEFINITIONS.—For the purpose of this section, the following definitions shall apply:

''(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under subsection (c).

''(2) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long distance mental health care, patient and professional-related education, public health, and health administration.

''(c) AUTHORIZATION.—

''(1) IN GENERAL.—The Secretary is authorized to award grants under the demonstration project for the provision of telemental health services to Indian youth who—

''(A) have expressed suicidal ideas;

''(B) have attempted suicide; or

''(C) have mental health conditions that increase or could increase the risk of suicide.

''(2) ELIGIBILITY FOR GRANTS.—Such grants shall be awarded to Indian Tribes and Tribal Organizations that operate 1 or more facilities—

''(A) located in Alaska and part of the Alaska Federal Health Care Access Network;

''(B) reporting active clinical telehealth capabilities; or

''(C) offering school-based telemental health services relating to psychiatry to Indian youth.

''(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

''(4) AWARDING OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian Tribes and Tribal Organizations that—

''(A) serve a particular community or geographic area where there is a demonstrated need to address Indian youth suicide;

''(B) enter in to collaborative partnerships with Indian Health Service or Tribal Health Programs or facilities to provide services under this demonstration project;

''(C) serve an isolated community or geographic area which has limited or no access to behavioral health services; or

''(D) operate a detention facility at which Indian youth are detained.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—An Indian Tribe or Tribal Organization shall use a grant received under subsection (c) for the following purposes:

''(A) To provide telemental health services to Indian youth, including the provision of—

''(i) psychotherapy;

''(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

''(iii) alcohol and substance abuse treatment.

''(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service, tribal, or urban clinicians and health services providers working with youth being served under this demonstration project.

''(C) To assist, educate and train community leaders, health education professionals

and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and with State and local health services providers.

''(D) To develop and distribute culturally appropriate community educational materials on—

''(i) suicide prevention;

''(ii) suicide education;

''(iii) suicide screening;

''(iv) suicide intervention; and

''(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

''(E) For data collection and reporting related to Indian youth suicide prevention efforts.

''(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian Tribe or Tribal Organization may use and promote the traditional health care practices of the Indian Tribes of the youth to be served.

''(e) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe or Tribal Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(1) a description of the project that the Indian Tribe or Tribal Organization will carry out using the funds provided under the grant;

''(2) a description of the manner in which the project funded under the grant would—

''(A) meet the telemental health care needs of the Indian youth population to be served by the project; or

''(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

''(3) evidence of support for the project from the local community to be served by the project;

''(4) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

''(5) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

''(6) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

''(f) COLLABORATION; REPORTING TO NATIONAL CLEARINGHOUSE.—

''(1) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

''(2) REPORTING TO NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall also encourage Indian Tribes and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

''(g) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

''(1) describes the number of telemental health services provided; and

''(2) includes any other information that the Secretary may require.

''(h) REPORT TO CONGRESS.—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a final report, based on the annual reports provided by grant recipients under subsection (h), that—

''(1) describes the results of the projects funded by grants awarded under this section, including any data available which indicates the number of attempted suicides;

''(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

''(3) evaluates whether the demonstration project should be—

''(A) expanded to provide more than 5 grants; and

''(B) designated a permanent program; and

''(4) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

''SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

''Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 710. TRAINING AND COMMUNITY EDUCATION.

''(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian Tribes and Tribal Organizations to develop and implement, within each Service Unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, Tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies, including Systems of Care, for preventing and treating behavioral health problems.

''SEC. 711. BEHAVIORAL HEALTH PROGRAM.

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

''(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with traditional health care practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 701 and acting through the Service, is authorized to establish and operate fetal alcohol disorder programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

''(2) USE OF FUNDS.—

''(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

''(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol disorders.

''(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

''(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected Indians and their families or caretakers.

''(iv) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

''(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

''(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

''(vii) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

''(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

''(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

''(ii) Community-based support services for Indians and women pregnant with Indian children.

''(iii) Community-based housing for adult Indians with fetal alcohol disorder.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities; and

''(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

''(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

''(1) The National Institute on Drug Abuse.

''(2) The National Institute on Alcohol and Alcoholism.

''(3) The Office of Substance Abuse Prevention.

''(4) The National Institute of Mental Health.

''(5) The Service.

''(6) The Office of Minority Health of the Department of Health and Human Services.

''(7) The Administration for Native Americans.

''(8) The National Institute of Child Health and Human Development (NICHD).

''(9) The Centers for Disease Control and Prevention.

''(10) The Bureau of Indian Affairs.

''(11) Indian Tribes.

''(12) Tribal Organizations.

''(13) urban Indian organizations.

''(14) Indian fetal alcohol spectrum disorders experts.

''(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

''(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 713. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

''(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

''(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

''(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

''(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

''(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

''SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

''(a) IN GENERAL.—The Secretary, in accordance with section 701, is authorized to establish in each Service Area programs involving the prevention and treatment of—

''(1) Indian victims of domestic violence or sexual abuse; and

''(2) perpetrators of domestic violence or sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—

''(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

''(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

''(3) to purchase rape kits;

''(4) to develop prevention and intervention models, which may incorporate traditional health care practices; and

''(5) to identify and provide behavioral health treatment to perpetrators who are Indian or members of an Indian household.

''(c) TRAINING AND CERTIFICATION.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

''(d) COORDINATION.—

''(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian Health Programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

''(A) to improve domestic violence or sexual abuse responses;

''(B) to improve forensic examinations and collection;

''(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

''(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

''SEC. 715. BEHAVIORAL HEALTH RESEARCH.

''The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the multifactorial causes of Indian youth suicide, including—

''(A) protective and risk factors and scientific data that identifies those factors; and

''(B) the effects of loss of cultural identity and the development of scientific data on those effects;

''(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(3) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

''SEC. 716. DEFINITIONS.

''For the purpose of this title, the following definitions shall apply:

''(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

''(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

''(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

''(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

''(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

''(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

''(B) INCLUSIONS.—The term 'fetal alcohol spectrum disorders' may include—

''(i) fetal alcohol syndrome (FAS);

''(ii) fetal alcohol effect (FAE);

''(iii) alcohol-related birth defects; and

''(iv) alcohol-related neurodevelopmental disorders (ARND).

''(6) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means any 1 of a spectrum of effects that may occur when a woman drinks alcohol during pregnancy, the diagnosis of which involves the confirmed presence of the following 3 criteria:

''(A) Craniofacial abnormalities.

''(B) Growth deficits.

''(C) Central nervous system abnormalities.

''(7) REHABILITATION.—The term 'rehabilitation' means medical and health care services that—

''(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

''(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

''(C) have as their purpose any of the following:

''(i) The maximum attainment of physical, mental, and developmental functioning.

''(ii) Averting deterioration in physical or mental functional status.

''(iii) The maintenance of physical or mental health functional status.

''(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''(9) SYSTEMS OF CARE.—The term 'Systems of Care' means a system for delivering services to children and their families that is child-centered, family-focused and family-driven, community-based, and culturally competent and responsive to the needs of the children and families being served. The systems of care approach values prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive array of services, individualized service planning, services in the least restrictive environment, and integrated services with coordinated planning across the child-serving systems.

''SEC. 717. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out the provisions of this title.

''TITLE VIII—MISCELLANEOUS

''SEC. 801. REPORTS.

''For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall transmit to Congress a report containing the following:

''(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population.

''(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and urban Indian organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 807.

''(3) A report on the use of health services by Indians—

''(A) on a national and area or other relevant geographical basis;

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) provided under contracts.

''(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

''(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(m).

''(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 125(f).

''(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

''(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

''(9) A biennial report to Congress on infectious diseases as required by section 212.

''(10) A report on environmental and nuclear health hazards as required by section 215.

''(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2)(B) and 301(d).

''(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

''(13) An annual report on the expenditure of non-Service funds for renovation as required by sections 304(b)(2).

''(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

''(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

''(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

''(17) A report on evaluation and renewal of urban Indian programs under section 505.

''(18) A report on the evaluation of programs as required by section 513(d).

''(19) A report on alcohol and substance abuse as required by section 701(f).

''(20) A report on Indian youth mental health services as required by section 707(h).

''(21) A report on the reallocation of base resources if required by section 807.

''(22) A report on the movement of patients between Service Units, including—

''(A) a list of those Service Units that have a net increase and those that have a net decrease of patients due to patients assigned to one Service Unit voluntarily choosing to receive service at another Service Unit;

''(B) an analysis of the effect of patient movement on the quality of services for those Service Units experiencing an increase in the number of patients served; and

''(C) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

''(23) A report on the extent to which health care facilities of the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.

''SEC. 802. REGULATIONS.

''(a) DEADLINES.—

''(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act, except sections 105, 115, 117, 202, and 409 through 414. The Secretary may promulgate regulations to carry out such sections using the procedures required by chapter 5 of title 5, United States Code (commonly known as the 'Administrative Procedure Act').

''(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 and shall have no less than a 120-day comment period.

''(3) FINAL REGULATIONS.—The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

''(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes, and Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes and Tribal Organizations from each Service Area.

''(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of

self-governance and the government-to-government relationship between the United States and Indian Tribes.

''(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. This consultation may be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(b) LACK OF PLAN.—The lack of (or failure to submit) such a plan shall not limit the effect, or prevent the implementation, of this Act.

''SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED TO INDIAN HEALTH SERVICE.

''Any limitation on the use of funds contained in an Act providing appropriations for the Department for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

''SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a federally recognized Indian Tribe.

''(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

''(4) Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

''SEC. 806. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) PROVISION OF SERVICES TO OTHER INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

''(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

''(B) the Secretary and the served Indian Tribes have jointly determined that—

''(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

''(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

''(2) ISDEAA PROGRAMS.—In the case of health programs and facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian Tribe or Tribal Organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian Tribe or Tribal Organization shall take into account the considerations described in paragraph (1)(B).

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 404 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or SCHIP reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

''(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian Tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian Tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian Tribes in the Service Area revoke their concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

''(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

''(2) DEFINITION.—For purposes of this subsection, the term 'non-Service health care practitioner' means a practitioner who is not—

''(A) an employee of the Service; or

''(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

''SEC. 807. REALLOCATION OF BASE RESOURCES.

''(a) REPORT REQUIRED.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be implemented only after the Secretary has submitted to Congress, under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) EXCEPTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is at least 5 percent less than the amount appropriated to the Service for the previous fiscal year.

"SEC. 808. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and urban Indian organizations of the findings and results of demonstration projects conducted under this Act.

"SEC. 809. MORATORIUM.

''During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 805 and 806, until the Service has submitted to the Committees on Appropriations of the Senate and the House of Representatives a budget request reflecting the increased costs associated with the proposed final rule, and the request has been included in an appropriations Act and enacted into law.

"SEC. 810. SEVERABILITY PROVISIONS.

''If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

"SEC. 811. USE OF PATIENT SAFETY ORGANIZATIONS.

''The Service, an Indian Tribe, Tribal Organization, or urban Indian organization may provide for quality assurance activities through the use of a patient safety organization in accordance with title IX of the Public Health Service Act.

"SEC. 812. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

''(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

''(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

''(2) TESTIMONY.—A person who reviews or creates medical quality assurance records for any Indian Health Program or Urban Indian Organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

''(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

''(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

''(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

''(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

''(E) To an officer, employee, or contractor of the Indian Health Program or Urban Indian Organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

''(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

''(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

''(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization.

''(d) DISCLOSURE FOR CERTAIN PURPOSES.—

''(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations's medical quality assurance programs.

''(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

''(e) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—A person or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

''(f) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5, United States Code.

''(g) LIMITATION ON CIVIL LIABILITY.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (a) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(h) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(i) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

''(j) DEFINITIONS.—In this section:

''(1) The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

''(2) The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

''(3) The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (2) and are produced or compiled by or for an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

''(k) CONTINUED PROTECTION.—Disclosure under subsection (c) does not permit redisclosure except to the extent such further disclosure is authorized under subsection (c) or is otherwise authorized to be disclosed under this section.

''(l) INCONSISTENCIES.—To the extent that the protections under the Patient Safety and Quality Improvement Act of 2005 and this section are inconsistent, the provisions of whichever is more protective shall control.

''(m) RELATIONSHIP TO OTHER LAW.—This section shall continue in force and effect, except as otherwise specifically provided in any Federal law enacted after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

"SEC. 813. CLAREMORE INDIAN HOSPITAL.

''The Claremore Indian Hospital shall be deemed to be a dependant Indian community

for the purposes of section 1151 of title 18, United States Code.

"SEC. 814. SENSE OF CONGRESS REGARDING LAW ENFORCEMENT AND METHAMPHETAMINE ISSUES IN INDIAN COUNTRY.

''It is the sense of Congress that Congress encourages State, local, and Indian tribal law enforcement agencies to enter into memoranda of agreement between and among those agencies for purposes of streamlining law enforcement activities and maximizing the use of limited resources—

''(1) to improve law enforcement services provided to Indian tribal communities; and

''(2) to increase the effectiveness of measures to address problems relating to methamphetamine use in Indian country (as defined in section 1151 of title 18, United States Code).

"SEC. 815. PERMITTING IMPLEMENTATION THROUGH CONTRACTS WITH TRIBAL HEALTH PROGRAMS.

''Nothing in this Act shall be construed as preventing the Secretary from—

''(1) carrying out any section of this Act through contracts with Tribal Health Programs; and

''(2) carrying out sections through 214, 701(a)(1), 701(b)(1), 701(c), 707(g), and 712(b), through contracts with urban Indian organizations.

The previous sentence shall not affect the authority the Secretary may otherwise have to carry out other provisions of this Act through such contracts.

"SEC. 816. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

''(b) LIMITATION ON NEW SPENDING AUTHORITY.—Any new spending authority (described in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93–344; 88 Stat. 317)) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

''(c) AVAILABILITY.—The funds appropriated pursuant to this Act shall remain available until expended.''.

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (6).'' and inserting ''Assistant Secretaries of Health and Human Services (7)''.

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services''.

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

''(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.'';

(B) in section 5 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

"SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.";

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY'';

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY''; and

(E) by striking ''Director'' each place it appears and inserting ''Assistant Secretary''.

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''; and

(B) in paragraph (2)(A), by striking ''the Directors referred to in such paragraph'' and inserting ''the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health''.

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

SEC. 3102. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

''TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

"SEC. 801. DEFINITIONS.

''In this title:

''(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

''(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

''(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

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

''(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

''(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—

''(A) be taken into consideration for purposes of determining Federal appropriations relating to the provision of health care and services to Indians; or

''(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

''(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

''(c) NATURE OF CORPORATION.—The Foundation—

''(1) shall be a charitable and nonprofit federally chartered corporation; and

''(2) shall not be an agency or instrumentality of the United States.

''(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

''(e) DUTIES.—The Foundation shall—

''(1) encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

''(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

''(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

''(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

''(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

''(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—

''(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

''(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

''(C) establish the constitution and initial bylaws of the Foundation;

''(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

''(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

''(g) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

''(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

''(3) SELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of

office of the members shall be as provided in the constitution and bylaws of the Foundation.

''(B) REQUIREMENTS.—

''(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

''(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

''(I) shall be appointed by the Committee not later than 180 days after the date on which the Foundation is established; and

''(II) shall have staggered terms.

''(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

''(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

''(h) OFFICERS.—

''(1) IN GENERAL.—The officers of the Foundation shall be—

''(A) a secretary, elected from among the members of the Board; and

''(B) any other officers provided for in the constitution and bylaws of the Foundation.

''(2) CHIEF OPERATING OFFICER.—The secretary of the Foundation may serve, at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

''(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

''(i) POWERS.—The Foundation—

''(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

''(2) may adopt and alter a corporate seal;

''(3) may enter into contracts;

''(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

''(5) may sue and be sued; and

''(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

''(j) PRINCIPAL OFFICE.—

''(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

''(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

''(k) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

''(l) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

''(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

''(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

''(m) RESTRICTIONS.—

''(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed the percentage described in paragraph (2) of the sum of—

''(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

''(B) donations received from private sources during the preceding fiscal year.

''(2) PERCENTAGES.—The percentages referred to in paragraph (1) are—

''(A) for the first fiscal year described in that paragraph, 20 percent;

''(B) for the following fiscal year, 15 percent; and

''(C) for each fiscal year thereafter, 10 percent.

''(3) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

''(4) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

''(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

''(o) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

''(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

''SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

''(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

''(1) may provide personnel, facilities, and other administrative support services to the Foundation;

''(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

''(3) shall require and accept reimbursements from the Foundation for—

''(A) services provided under paragraph (1); and

''(B) funds provided under paragraph (2).

''(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

''(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

''(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

''(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

''(1) are available; and

''(2) are provided on reimbursable cost basis.''.

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking ''section 501'' and inserting ''section 701''.

SEC. 3103. GAO STUDY AND REPORT ON PAYMENTS FOR CONTRACT HEALTH SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the utilization of health care furnished by health care providers under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian Tribe, or a Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for such health care through other public programs and in the private sector;

(B) barriers to accessing care under such contract health services program, including, but not limited to, barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under such program;

(C) the adequacy of existing Federal funding for health care under such contract health services program; and

(D) any other items determined appropriate by the Comptroller General.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations regarding—

(1) the appropriate level of Federal funding that should be established for health care under the contract health services program described in subsection (a)(1); and

(2) how to most efficiently utilize such funding.

(c) CONSULTATION.—In conducting the study under subsection (a) and preparing the report under subsection (b), the Comptroller General shall consult with the Indian Health Service, Indian Tribes, and Tribal Organizations.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

SEC. 3201. EXPANSION OF PAYMENTS UNDER MEDICARE, MEDICAID, AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.

(a) MEDICAID.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

''SEC. 1911. INDIAN HEALTH PROGRAMS.'';

and

(B) by amending subsection (a) to read as follows:

''(a) ELIGIBILITY FOR PAYMENT FOR MEDICAL ASSISTANCE.—An Indian Health Program shall be eligible for payment for medical assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Program if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title and under such plan or waiver authority.''.

(2) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is amended to read as follows:

''(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan or under waiver authority. This subsection shall not be construed to impair the entitlement of a State to reimbursement for such medical assistance under this title.''.

(4) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—Such section is further amended by striking subsection (d) and adding at the end the following new subsections:

''(c) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

''(d) DIRECT BILLING.—For provisions relating to the authority of an Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.''.

(5) DEFINITIONS.—Section 1101(a) of such Act (42 U.S.C. 1301(a)) is amended by adding at the end the following new paragraph:

''(11) For purposes of this title and titles XVIII, XIX, and XXI, the terms 'Indian Health Program', 'Indian Tribe' (and 'Indian tribe'), 'Tribal Health Program', 'Tribal Organization' (and 'tribal organization'), and 'urban Indian organization' (and 'urban Indian organization') have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

(b) MEDICARE.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1880 of such Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

''SEC. 1880. INDIAN HEALTH PROGRAMS.'';

and

(B) by amending subsection (a) to read as follows:

''(a) ELIGIBILITY FOR PAYMENTS.—Subject to subsection (e), an Indian Health Program shall be eligible for payments under this title with respect to items and services furnished by the Program if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title.''.

(2) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

(3) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—

(A) IN GENERAL.—Such section is further amended by striking subsections (c) and (d) and inserting the following new subsections:

''(b) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

''(c) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.''.

(B) CONFORMING AMENDMENTS.—Such section is further amended—

(i) in subsection (e)(3), by striking ''Subsection (c)'' and inserting ''Subsection (b) and section 401(b)(1) of the Indian Health Care Improvement Act'';

(ii) by redesignating subsection (e) as subsection (d); and

(iii) by striking subsection (f).

(4) DEFINITIONS.—Such section is further amended by amending adding at the end the following new subsection:

''(e) DEFINITIONS.—In this section, the terms 'Indian Health Program', 'Indian Tribe', 'Service Unit', 'Tribal Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

(c) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (K) through (M) as subparagraphs (L) through (N), respectively; and

(2) by inserting after subparagraph (J), the following new subparagraph:

''(K) Section 1911 (relating to Indian Health Programs, other than subsection (c) of such section).''.

SEC. 3202. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) ASSURANCE OF PAYMENTS TO INDIAN HEALTH CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—Section 2102(b)(3)(D) of the Social Security Act (42 U.S.C. 1397bb(b)(3)(D)) is amended by striking ''(as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c))'' and inserting '', including how the State will ensure that payments are made to Indian Health Programs and urban Indian organizations operating in the State for the provision of such assistance''.

(b) INCLUSION OF OTHER INDIAN FINANCED HEALTH CARE PROGRAMS IN EXEMPTION FROM PROHIBITION ON CERTAIN PAYMENTS.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by striking ''insurance program, other than an insurance program operated or financed by the Indian Health Service'' and inserting ''program, other than a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or urban Indian organization''.

(c) DEFINITIONS.—Section 2110(c) of such Act (42 U.S.C. 1397jj(c)) is amended by adding at the end the following new paragraph:

''(9) INDIAN; INDIAN HEALTH PROGRAM; INDIAN TRIBE; ETC.—The terms 'Indian', 'Indian Health Program', 'Indian Tribe', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. 3203. SOLICITATION OF PROPOSALS FOR SAFE HARBORS UNDER THE SOCIAL SECURITY ACT FOR FACILITIES OF INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.

The Secretary of Health and Human Services, acting through the Office of the Inspector General of the Department of Health and Human Services, shall publish a notice, described in section 1128D(a)(1)(A) of the Social Security Act (42 U.S.C. 1320a–7d(a)(1)(A)), soliciting a proposal, not later than July 1, 2010, on the development of safe harbors described in such section relating to health care items and services provided by facilities of Indian Health Programs or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act). Such a safe harbor may relate to areas such as transportation, housing, or cost-sharing, assistance provided through such facilities or contract health services for Indians.

SEC. 3204. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by the sections 3203 and 3204, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

''(e) ANNUAL REPORT ON INDIANS SERVED BY HEALTH BENEFIT PROGRAMS FUNDED UNDER THIS ACT.—Beginning January 1, 2011, and annually thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

''(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

''(2) The number of Indians described in paragraph (1) that also received health benefits under programs funded by the Indian Health Service.

''(3) General information regarding the health status of the Indians described in paragraph (1), disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(4) A detailed statement of the status of facilities of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization with respect to such facilities' compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI, and, in the case of title XIX or XXI, under a State plan under such title or under waiver authority, and of the progress being made by such facilities (under plans submitted under 1911(b) or otherwise) toward the achievement and maintenance of such compliance.

''(5) Such other information as the Secretary determines is appropriate.''.

SEC. 3205. DEVELOPMENT OF RECOMMENDATIONS TO IMPROVE INTERSTATE COORDINATION OF MEDICAID AND SCHIP COVERAGE OF INDIAN CHILDREN AND OTHER CHILDREN WHO ARE OUTSIDE OF THEIR STATE OF RESIDENCY BECAUSE OF EDUCATIONAL OR OTHER NEEDS.

(a) STUDY.—The Secretary shall conduct a study to identify barriers to interstate coordination of enrollment and coverage under the Medicaid program under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act of children who are eligible for medical assistance or child health assistance under such programs and who, because of educational needs, migration of families,

emergency evacuations, or otherwise, frequently change their State of residency or otherwise are temporarily present outside of the State of their residency. Such study shall include an examination of the enrollment and coverage coordination issues faced by Indian children who are eligible for medical assistance or child health assistance under such programs in their State of residence and who temporarily reside in an out-of-State boarding school or peripheral dormitory funded by the Bureau of Indian Affairs.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary, in consultation with directors of State Medicaid programs under title XIX of the Social Security Act and directors of State Children's Health Insurance Programs under title XXI of such Act, shall submit a report to Congress that contains recommendations for such legislative and administrative actions as the Secretary determines appropriate to address the enrollment and coverage coordination barriers identified through the study required under subsection (a).

The SPEAKER pro tempore. After 4 hours of debate on the bill, as amended, equally divided among and controlled by the Chair and ranking minority member of the Committee on Energy and Commerce, the Chair and ranking minority member of the Committee on Ways and Means, and the Chair and ranking minority member of the Committee on Education and Labor, the further amendment printed in part C of the report, if offered by the gentleman from Michigan (Mr. STUPAK) or his designee, shall be considered read, and shall be debatable for 20 minutes, equally divided and controlled by the proponent and an opponent. The further amendment in the nature of a substitute printed in part D of the report, if offered by the gentleman from Ohio (Mr. BOEHNER) or his designee, shall be considered as read, and shall be debatable for 1 hour equally divided and controlled by the proponent and an opponent.

The gentleman from California (Mr. WAXMAN), the gentleman from Texas (Mr. BARTON), the gentleman from New York (Mr. RANGEL), the gentleman from Michigan (Mr. CAMP), the gentleman from California (Mr. GEORGE MILLER), and the gentleman from Minnesota (Mr. KLINE) each will control 40 minutes.

The Chair now recognizes the gentleman from California (Mr. WAXMAN).

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Mr. WAXMAN. Mr. Speaker, I am pleased to start off the debate by recognizing our very distinguished majority leader, STENY HOYER from the State of Maryland, for 1 minute.

Mr. HOYER. I thank Mr. WAXMAN for yielding.

Our rule was chaired by JOHN DINGELL, himself a historic figure on a historic day.

I want to congratulate all of those who have participated in the accomplishment of the product that we consider this day: Mr. WAXMAN, one of our senior Members in the House; Mr. RANGEL, one of our senior Members in the House; and Mr. MILLER.

I want to thank too the Republicans who engaged in this discussion, in this debate, because it is historic, and all of us who sit in this Chamber know that it will have a great effect on our people. Some perceive that effect as not positive. More, I believe, think it is positive. In any event, none of us believe that it is not extraordinarily important.

Soon each one of us is going to look into his or her conscience and vote on this bill. And when the time comes, I don't know if any words of mine will sway any of you. But I know that the most powerful arguments for the bill won't be spoken on this floor. They are being lived right now in our country in every one of our districts, in every one of our towns and counties and municipalities.

In the anxiety of the family that finds itself paying more and more each year for health insurance that grows weaker and weaker.

In the frustration of the small business owner weighing the choices of dropping her employees' coverage against the threat of being driven out of business by her competitors.

And in the fury of the patient who learns that an insurance company bureaucrat has deemed him too sick for the coverage he paid for.

They are our families, our neighbors, our fellow citizens. They are waiting for health insurance reform that is more affordable, more secure, more just. Their stories will be with me and I know with each of us when we cast our vote.

Because I want to say to every American facing down illness: never again, never again will you be denied coverage because you have diabetes or asthma or some other disease or because you're pregnant or because you have anything else your insurer decides is a preexisting condition. Never again will your coverage run out. Nor will you find the coverage you thought you had paid for was actually not there at all. And never again can insurance companies drive out competition and set premiums as high as they like, because there will be a public insurance option and a transparent marketplace to keep them honest, to keep them competitive, to bring prices down.

I want to say to our middle class families, the backbone of our country: you will have coverage that you can depend upon. Even if you change your job or lose your job or decide to start a business, you will be able to find affordable coverage in a competitive marketplace, an insurance exchange that offers you a choice of good policies at fair rates. In fact, according to an MIT analysis, buying coverage on the exchange will bring your premiums down by a great deal, even without the affordability credits.

If your family makes $90,000 or more, you'll save more than 1,200 bucks. If your family makes $60,000, you'll save more than $5,000. And if your family is making $38,000, you'll save more than $9,000. That's the kind of tax cut that America needs to secure its medical future.

I want to say to our seniors: you can count on Medicare, on a Federal program, for dignity and peace of mind in your golden years. And that will not change. Today we will vote to protect your access to your doctor, to encourage Medicare physicians to cooperate on higher quality care, to keep your Medicare solvent for longer, and to bring an end to the doughnut hole that leaves prescription drugs unaffordable for so many.

I want to say to our small businessmen and women: I know your premiums keep going up and that each year they make it harder to stay in business, to compete with Big Business and with foreign firms. You deserve a fair playing field; and in the insurance exchange marketplace, you'll be able to buy coverage at the low group rates you're now being denied.

I want to say to the 35 million Americans without insurance, who are forced to skip checkups and preventative care, who are forced to turn to the ER as the first and only line of defense, who live sicker and shorter lives: you will have what every man, woman, and child has in every other industrialized country in the world: health coverage you can afford and that you can count on.

And every American who is rightly worried about our mounting deficits and debt, I can tell you this: this bill does not add to the deficit over the next 10 years or the 10 years thereafter. This bill means health care that is more fiscally sustainable for years to come.

That is what this bill, the Affordable Health Care for America Act, can achieve for our country and for our people. It isn't a simple bill. It isn't a perfect bill, but it is the product of months and months of careful debate, sometimes animated debate, yes, even angry debate, careful scrutiny, hard work, and citizen input. And it's the right response to this time of economic insecurity in which we have been called to lead.

If we miss this chance, or if we vote for a Republican plan that does very little to expand coverage, weakens insurance, frankly, for millions who have it, and continues to allow millions of Americans to be denied affordable coverage, we'll find ourselves back here again.

But by then, premiums will eat up even more of our families' budgets; health care will consume even more of our economy; and even more Americans will have died for the lack of health care.

If we miss this chance, if we miss this challenge of nearly a century's duration, when Teddy Roosevelt, one of the great Presidents of this country, a Republican President of this country, said a hundred years ago we need to have health care coverage for all Americans—this is not a new idea, but it is

an idea whose time has surely come—the years between this chance and our next one will be filled with stories that are unworthy of America at its best.

Stories like Linda's, who wrote to The New York Times of the anguish she felt suffering from abdominal cancer and standing in the hospital just feet away from the drugs that could help save her life, drugs her insurance company was denying her.

Stories like Deamonte Driver's from Prince George's County, just a few miles down the road, who died at the age of 12 from a toothache, a toothache that was not treated by a dentist; and, as a result, it became infected. That infection went into his brain. He was in the hospital for 30 days at a cost of $250,000. Why? Because he didn't have $80 to get that tooth filled.

This bill will change that. We can be better than that. America is better than that. We must be.

Americans rightly want to know what's in this bill for them and for their families, but there's also something important in this bill for us as a people: a system worthy of the values we profess and the principles we hold dear. We will vote for a healthier America. We will vote to give our fellow citizens a greater sense of security. We will vote to make Medicare stronger for our seniors. We will vote for a healthier economy, for affordable coverage for individuals and small business. We will vote to begin containing costs, which will otherwise be unsustainable for our children and for our grandchildren.

We will, in sum, my colleagues, on this historic day, vote for a more perfect Union of which our Founders dreamed.

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 2 minutes.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, I first want to apologize to my wife, Terry. Back in September for my 60th birthday, she gave me a birthday present of a weekend in Las Vegas today. I obviously can't be there because I have to be here doing my duty for the 6th District of Texas. But like many of us, we wear two hats. So to my wife and all the families that had things planned this weekend, I do want to apologize.

I would also point out that my wife works for a public hospital in Fort Worth, Texas; and this is something that's very, very dear to her heart.

Mr. Speaker, there are many reasons to oppose the bill before us, H.R. 3962. There are numerous policy reasons. It's going to cost over $1.2 trillion over 10 years if you include the physician reimbursement fix in the separate bill. When fully implemented, it's my opinion that two-thirds to three-fourths of every dollar spent on health care in America is going to be spent by the Federal Government in some shape, form, or fashion. It's going to create, in my opinion, Mr. Speaker, a two-tiered health care system: the public system for most of us and then a private system for the elites of the country that can afford to go outside the public system.

It's a bad deal for average Americans. The average person today who works and has a health care plan through their employer, the average plan costs about $10,000 a year. The employee pays $3,500; the employer pays $6,500. Since there's an 8 percent payroll tax, on the average of $40,000, that would be about $3,200. Most employers, when this plan is implemented, can pay the 8 percent tax, which is $3,200, or the $6,500 premium that they pay for their employees.

They're going to stop providing health care through the employment and they're just going to put them in the public option. The employee is going to take that $3,500 that he or she was paying for their premium for a $10,000 plan and they're going to find out that when they go into the health care exchange, their $3,500 doesn't buy a $10,000 policy. It buys a $3,500 policy. It's a bad deal.

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

Mr. BARTON of Texas. Mr. Speaker, I yield myself 1 more minute.

So there are lots of policy reasons.

But the real reason, Mr. Speaker, is that I just don't think it's right, in the guise of helping Americans, to mandate what they have to do. I don't think it's right to mandate that you have to have health insurance or you might go to jail. I don't think it's right that you mandate an employer to provide health care insurance or they're going to pay all these penalties. I don't think it's right that we set up a health choice administration that sets what the health care plans have to be. I don't think it's right that you say that 70 to 90 percent of those premiums of the benefit package that is mandated has to be paid by the employer.

I just don't think mandating to Americans is a good idea, except in a few cases. To protect the country in times of war, we have on occasion had to mandate our young men, and now our young women, to have to serve. We mandate we have to pay our taxes. But we don't have to mandate that you need health insurance.

Vote ''no'' on the bill and ''yes'' on the Republican substitute.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 3 minutes to the majority whip of the House of Representatives, Mr. CLYBURN.

Mr. CLYBURN. I thank Chairman WAXMAN for yielding me the time.

Mr. Speaker, today I'm thinking about a woman from South Carolina. A few months ago during the August break, I participated in a talk radio program on health reform, and a gentleman called in to tell me that his health care was great, and he didn't want me or the government to mess with it.

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I explained to him that our plan was about choice, bringing down costs, and providing quality care.

But the next caller got right to the heart of the matter. She said, Of course he likes his health insurance; it is probably because he has never tried to use it. She explained that she had recently been diagnosed with cancer and thought she liked her coverage until she tried to use it. She said that when she began to get treatment she was dropped from her insurance coverage.

Mr. Speaker, that is why we are here today, to respond to that caller and others who have asked, What's in this plan for me?

When this bill is signed into law, 15 reforms will immediately occur. Among them are: beginning to close the doughnut hole by increasing Medicare part D coverage by $500; increased funding for community health centers, doubling the number of patients seen over 5 years; extending coverage for young people to stay on their parents' insurance plans up to their 27th birthday; access for the uninsured with preexisting conditions to a temporary insurance plan that we are calling a high-risk pool; from the date of enactment, and until the exchange is available, insurers will be prohibited from dropping your coverage if you get sick; from the date of enactment, COBRA health insurance coverage will be extended until the exchange is available and displaced workers can have affordable coverage; and from the date of enactment, we will hinder price-gouging with sunshine requirements on insurance companies to disclose insurance rate increases.

Now, after 2013, when the mandate for coverage and exchange are in place, you will see three additional protections: no more copays for routine checkups and preventive care; no lifetime or yearly caps on what insurance companies will cover; there will be yearly caps on your out-of-pocket expenses; and, as has been said so often, there will be an end to discrimination because of preexisting conditions like diabetes, heart disease or cancer.

Mr. Speaker, these are just 11 reasons to support this bill. My colleagues will share with you many others.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a member of the committee, the gentleman from Illinois (Mr. SHIMKUS).

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, I think it spoke volumes that my friend, JOHN DINGELL, chaired the rule. JOHN DINGELL has always been a single-payer advocate. That speaks volumes to what the real intent of this bill is.

The goal of this legislation has been clear: to pass a public option that will serve as a gateway to a single-payer,

government-controlled system. Don't trust me; ask my friend, JAN SCHAKOWSKY, or ask Chairman BARNEY FRANK. Or believe President Obama who said, ''I happen to be a proponent of a single-payer health care program. But I don't think we're going to be able to eliminate employer coverage immediately.''

Make no mistake, this bill will achieve the single-payer goal. And along with it, it will raise premiums, increase taxes, cuts billions of dollars from Medicare, and cost millions of working Americans their job. And at the end, a single-payer system will force every American into a one-size-fits-all system that rations care. A government that rations care is anti-life.

Mr. WAXMAN. Mr. Speaker, at this time I am very pleased to recognize and to yield 1 minute to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise at this historic moment in support of the Affordable Health Care for America Act. None of us will again have such an opportunity in our time serving in the United States Congress to do something so enduring and fulfilling, to make sure that every American shall have access to quality, affordable health insurance.

For more than a century, the special interests have won this moment. Presidents Theodore and Franklin Roosevelt, Truman, Kennedy, Nixon, and Clinton have spoken of our country's aspiration, but only now have we come so far.

When the Democrats and the Congress passed Medicare, we lifted seniors out of poverty forever, and now we get to say to working Americans, You can no longer be broken by a health insurance system that drops you when you are sick or lose a job.

It says to women, You will no longer be denied coverage on account of a C-section or domestic violence. No longer will maternity or preventive care be ignored.

I urge my colleagues to vote for history and for America today. This is why we are here.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to the gentlewoman from California (Mrs. BONO MACK), a member of the committee.

Mrs. BONO MACK. Mr. Speaker, I rise today to express my strong opposition to this bill. It is a bill that flies in the face of the Hippocratic oath which both my father and grandfather took as young doctors, which says, ''Do no harm.''

In fact, this bill does a tremendous amount of harm and would inflict an enormous burden on current and future generations of Americans. It would raise insurance premiums, raise taxes, and create huge new government bureaucracies to stand squarely between patients and doctors.

This bill does not offer real health care reform. Rather than reduce costs and make health care more affordable and accessible, this bill will increase costs to consumers and put the government in charge of deciding what treatment and care Americans are entitled to.

Millions of Americans have resoundingly rejected this shell game masquerading as reform. The very least we can do is listen to the American people and reject this flawed bill.

Mr. WAXMAN. Mr. Speaker, I am pleased now to yield 2 minutes to the gentleman from Connecticut (Mr. LARSON), the chairman of the Democratic Caucus.

Mr. LARSON of Connecticut. Mr. Speaker, I thank Mr. WAXMAN and Mr. RANGEL and Mr. MILLER for their help.

The growth of this great Nation cannot be achieved without caring for the health of all of its citizens. Thirty-six million Americans await our action on the House floor today. Thirty-six million Americans watched as the fearmongers stood on the steps of the Capitol this week telling them to be afraid.

The same fear was spread during the debate on Social Security and Medicare. Today, we will put a stop to the fear and address the real threat, the real danger the American people face. The woman next to you on the train spreading the flu because she couldn't afford to see a doctor. The little boy in the sandbox with your child whose parents couldn't afford the vaccinations. And if we have learned anything from the H1N1 epidemic, the billions of dollars these public health emergencies cost all of us, and that disease has no boundaries or borders; it affects all of us.

On this historic day, this Congress will pass what will improve both the fiscal and physical health of the entire Nation by improving health care for all of our citizens. It is a statement of our values. It is testimony to how we care for our fellow citizens. It is at the very core of all that America stands for and why we came here to serve. Thirty-six million Americans deserve nothing less.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. DEAL), a subcommittee ranking member.

Mr. DEAL of Georgia. Mr. Speaker, I rise in opposition to this bill, and I express three major concerns.

First of all, I raise a question. The question is: what authority in the United States Constitution gives this Congress the right to mandate that every citizen must purchase a health insurance policy, and upon failing to do so, shall be fined and possibly imprisoned? I think the answer to that question is, there is no such congressional authority.

Secondly, make no mistake about it, illegal aliens will receive government-funded health care under this because all they are required to show is a Social Security number and a name. There is no way to prevent the same Social Security number from being used by numerous individuals, and there is no requirement that a picture ID be produced in order to prove that the person is in fact the name that appears on the Social Security card. If you think identity theft is a problem now, just wait until this bill passes.

Thirdly, this bill requires States to increase their Medicaid rolls to 150 percent of the Federal poverty level. In an ever-increasing fashion, States will have to absorb the cost of this burden. I offered an amendment which would have allowed States to opt out from under this mandate, but it has been rejected. In States like mine, where we have to balance our budget, right now schoolteachers and law enforcement officers are having to take unfunded furlough days. If this bill passes, it will get even worse. We should not be passing a bill that takes days and money out of the paychecks of teachers and law enforcement officers to pay for this piece of legislation.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from the State of Maryland, Mr. CHRIS VAN HOLLEN.

Mr. VAN HOLLEN. Mr. Speaker, today our Nation stands at an historic crossroads. We can choose the road that dead-ends in the status quo where the health industry will continue to call the shots and ration our health care or we can pass this bill and take the path that will provide every American citizen access to quality, affordable health care.

What we do in this bill is preserve what is best and fix what is broken. We currently face unsustainable skyrocketing health care costs that are breaking our family's budget, forcing businesses to drop health insurance, and will eventually bankrupt our Nation. We saw health insurance premiums more than double between 2000 and 2008; and during that period of time, health insurance profits soared by 500 percent. How did they do it? Essentially by saying ''no'' to people who had preexisting conditions and using the fine print in insurance policies to deny people promised benefits when they needed help the most.

This bill will end those abuses. It ends the antitrust exemption that

shielded the health insurance industry from price-fixing. It establishes a health insurance exchange like a shopping supermarket for health policies that provides more choice, including a public option.

Mr. Speaker, that's why the Consumers Union and Consumer Reports support this legislation. That's why the AARP, the largest organization protecting the rights of seniors, has endorsed this. And that's why the doctors of America have endorsed this.

□ 1430

I understand why the insurance industry opposes this bill, but our job is not to protect the special interests of the insurance industry; our job is to do what's right by the American people.

Let's move this country forward. Let's vote ''yes'' for America.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to another member of the committee, Congresswoman MARSHA BLACKBURN of Nashville, Tennessee.

Mrs. BLACKBURN. Mr. Speaker, I find it so interesting that some are so excited about voting for this bill. Quite frankly, I find it to be a very sad day that this body would take a step moving toward a single-payer system in health care.

We have all heard the horror stories of what happens in Europe and in Canada as women seek to get care for breast cancer and die before that care can be found, because care delayed is care denied. We've heard about heart surgeries that never came to pass because they were waiting in the queue. We have talked to mothers who sought desperately to have children treated for chronic illnesses and could not get that help. We have heard about our seniors, and we know what this bill will do to Medicare, making one-half trillion dollars worth of cuts. We have talked to mothers who have said, My goodness, you cannot even get H1N1 vaccine out there and you think you're going to handle the health care for my children?

And today, recorded in the Wall Street Journal, Betsy McCaughey, former Lieutenant Governor of New York, cites some of the provisions and what it will do to the seniors in this Nation as it cuts into their access.

This is not the action we should take.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

The Chair would ask all Members to adhere to the time limits and to heed the gavel.

Mr. WAXMAN. Mr. Speaker, I yield myself 3 minutes.

Today, we have a historic opportunity. Sixty-five years after Franklin Roosevelt and Social Security and 35 years after Medicare, we have an opportunity, under the leadership of President Obama and Speaker PELOSI, to reform our health care system and at last provide coverage to all Americans.

We know that health insurance today is failing our families and our economy. If we do nothing, the system will go bankrupt, premiums will keep skyrocketing, benefits will be slashed, what you get will cost more, and the deficit will increase by billions of dollars.

Today, Americans with health insurance know that they are one serious illness away from debt and bankruptcy, and millions of Americans have no insurance at all. With this legislation, we can fix these problems.

First and foremost, this bill provides health insurance security for all Americans. If you have health insurance today, you can keep it; you keep your doctor and your other health providers. But if you lose your job, you will not lose your health insurance. If you have a preexisting medical condition, you cannot be denied health insurance. If you have a serious illness, we remove the cap insurance companies have imposed on paying for treatments over your lifetime. Effective immediately, it will be illegal for insurance companies to put lifetime caps on your coverage. And children all the way up to age 27 can continue on their parents' policies.

Our bill has historic reforms. It expands coverage and reduces costs. It trains doctors and supports community health centers. It provides a public health insurance option that will give Americans more choice and competition.

Our legislation strengthens Medicare. We will eliminate copayments for preventive services. We close and then eliminate the doughnut hole that makes prescription drugs unaffordable for so many of our seniors.

And this legislation is affordable. The only thing not affordable is to do nothing. The legislation is fully paid for. It will not add to the deficit over the next two decades.

Today, we have the chance of a lifetime to do something great and momentous for the American people. By passing this bill, we can reform health insurance in America and provide all Americans with the security of knowing that when they get sick, care will be available and affordable.

I urge all my colleagues to support this bill.

Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield for a unanimous consent request to the former chairman of the Appropriations Committee, Mr. BILL YOUNG of Florida.

(Mr. YOUNG of Florida asked and was given permission to revise and extend his remarks.)

Mr. YOUNG of Florida. Mr. Speaker, I rise in opposition to the bill.

Mr. Speaker, this bill, H.R. 3962, does not represent good public policy. I rise to express my concerns about H.R. 3962, the Affordable Health Care for America Act.

This legislation is misnamed, as even the nonpartisan Congressional Budget Office says it will not be affordable for the American people and our nation as a whole.

The Congressional Budget Office says this legislation will cost $1.055 trillion over the next 10 years, raising taxes on American taxpayers and businesses by $729.5 billion. Of great concern to me, and the 138,647 Medicare beneficiaries I represent, is that it will also cut Medicare payments by $500 billion. There is no possible way you can cut such a significant amount of funding out of a program that is so vital to senior citizens without compromising the availability or quality of their care and without disrupting the relationship they have with their current doctors and medical providers.

Within the Medicare program, H.R. 3962 also cuts the reimbursement rate for seniors enrolled in Medicare Advantage programs. In the 10th Congressional District of Florida which I represent, more than one-third of the Medicare beneficiaries, or 47,729 seniors, are currently enrolled in Medicare Advantage plans. The Chief Actuary of the Centers for Medicare and Medicaid Services estimates that if enacted, the legislation we consider today would cut enrollment in Medicare Advantage by 64 percent over 4 years. This means that more than 30,500 of the seniors I represent will lose or have to give up the health care coverage they currently have and like. This violates the number one promise made by the sponsors of this legislation, who say that if you like your current health care coverage, you can keep it.

The Congressional Budget Office also notes that changes in this legislation to the Medicare Part D program will, in the end, drive up Part D premiums by as much as 20 percent. These are additional premiums that seniors living on fixed incomes will have to pay to keep their prescription drug coverage.

Finally, with regard to Medicare, this legislation does nothing to correct a 21 percent cut in physician reimbursement rates that is scheduled to take effect January 1st for doctors who provide care to our seniors. Having met with doctors I represent throughout the past year, I know that one of their major concerns about health care reform is that they will be asked to take larger and larger cuts in Medicare reimbursement rates. These cuts, they say, will make it more and more difficult for them to care for Medicare patients. In the end, many seniors could be forced to find new doctors.

In addition to the impact this legislation would have on senior citizens, I am concerned about the economic impact this legislation will have on those seniors, their children, their grandchildren, and their great grandchildren. H.R. 3962 creates a brand new federal entitlement program at a time when our nation is struggling to sustain those entitlement programs already on the books. While the Congressional Budget Office says that under a best case scenario the $500 billion in Medicare cuts and $729.5 billion in tax increases will pay for this legislation over its first 10 years if there are no unexpected costs, it is doubtful that this will keep the program from running up federal deficits after that and leaves no margin for error.

In fact, despite one of the goals of this legislation to make health insurance more available and affordable for uninsured Americans, we simply move an estimated 18 million people into the government Medicaid program. This is more than half of the 34 million uninsured

Americans who the Chief Actuary of the Centers for Medicare and Medicaid Services says will receive coverage under this legislation.

Of the 13 million uninsured Americans who will receive coverage under the Health Insurance Exchange program created in this legislation, the Chief Actuary estimates that 40 percent, or 5.2 million, will take advantage of the government subsidized public option created by H.R. 3962.

The creation of a government subsidized public option is another major concern of the large majority of my constituents who have called and written me in opposition to this legislation. We are concerned about the insertion of the federal government into the precious patient-doctor relationship. At last count, this 1,990 page bill creates more than 100 new boards, bureaucracies, commissions and programs. Among those created by the bill is the ''Health Benefits Advisory Committee,'' that would be chaired by the U.S. Surgeon General, to make recommendations on cost and coverage issues.

This 27-member government committee of unelected administrators will be in charge of advising other bureaucrats, who will then decide what procedures American citizens are allowed to have and what doctors you are allowed to see under your healthcare plan. This places another layer of bureaucracy between you and your doctor.

This committee is in addition to another newly created federal organization called the ''Health Choices Administration,'' which will be governed by a new Commissioner who will distribute billions of dollars of taxpayer-funded subsidies. Additionally, the Commissioner will have complete control over all insurance plans offered through the newly created Health Insurance Exchange.

Perhaps the toughest of the mandates handed down by the federal government under this legislation is that businesses must provide health care for their employees or pay an 8 percent payroll tax and that individuals must purchase health insurance or pay a 2.5 percent tax on their adjusted gross income. This is not the federal government providing incentives to individuals or employers. This is the federal government imposing its will on individuals and businesses, and penalizing those who do not comply.

This legislation further penalizes small businesses by imposing a 5.4 percent surtax on individuals earning more than $500,000. Half of these so-called ''high earners'' are small business owners. Just imagine how small business owners all across our nation will react to this $544 billion in new federal taxes they will pay over the next 10 years. With the unemployment rate nationally at 10.2 percent and 11.4 percent in Florida, Congress should not be making it harder for business owners to create new jobs.

Finally, at a time when we are trying to lower health care costs, this legislation imposes a new 2.5 percent excise tax on the cost of wheelchairs, portable oxygen systems, diabetes testing equipment, and a whole range of other medical devices. This tax will be paid by our constituents who have no choice but to purchase this medical equipment and who may already be stretched thin by other medical costs.

Mr. Speaker, I have discussed here some of my concerns about provisions in this bill; however there are glaring omissions to this legislation as well. The most significant provision that has been left out is medical liability reform. This is a top issue for doctors, hospitals and all medical providers, as it is one of the major drivers increasing the cost of health care. Tort reform would help reduce the filing of unwarranted lawsuits, decrease the number of duplicative tests that are a part of defensive medicine, and lower the cost of medical malpractice insurance rates, which would translate in lower medical costs.

Tort reform is one of the many areas that we can and should be able to agree upon to increase the availability and decrease the cost of health care. There are others I support, some in this bill, including requiring coverage for individuals with pre-existing conditions, preventing insurance companies from cancelling the policies of individuals when they become sick, providing for the availability of health insurance across state lines, ensuring that employees can retain access to health insurance when they change or lose their jobs, creating health insurance pools that small business owners and self-employed individuals can join to provide lower cost health insurance for their employees and themselves, and closing the so-called doughnut hole in the Medicare Part D prescription drug program.

Mr. Speaker, there is no doubt that our nation can and should do better to provide quality and affordable health care for the American people. Throughout my service in Congress, I have done all I could to expand health care opportunities nationally and throughout the 10th Congressional District, which I represent.

By establishing the National Marrow Donor Program in 1986, I sought to provide life-saving medical options to terminally ill patients suffering from leukemia and more than 60 otherwise fatal blood disorders. Today the national registry has more than 7 million volunteers available to donate the life-saving bone marrow.

During the time that I worked to establish the national registry and as we began to find matched marrow donors for patients, I met with family after family who needed help convincing health insurance companies to cover the marrow transplant procedure. From this experience, I witnessed first-hand the tragedy of families losing their health insurance coverage at their time of greatest need and of being denied coverage for a life-saving procedure.

In a similar manner, I have identified other national and local health care needs and have done something to solve the problems that include increasing the vaccination rates for our nation's children; ensuring the availability of specialized services, facilities and equipment at our nation's hospital emergency rooms to meet the needs of children; expanding the funding for graduate medical education programs to increase the number of doctors who receive the next step of their training; increasing the Inspector General force at federal agencies to uncover waste, fraud and abuse which threaten the safety of seniors and veterans, and divert limited federal health care resources; improving the quality of health care through our investment in biomedical research by doubling the budget for the National Institutes of Health during my 6 years as Chairman of the Appropriations Committee; expanding other research opportunities through the Department of Defense in the areas of breast cancer, prostate cancer, Parkinson's Disease, ALS, multiple sclerosis and diabetes; and expanding the number of community health centers throughout Florida and Pinellas County.

Mr. Speaker, I take a back seat to no one when it comes to my work to improve and expand the quality and availability of health care for the American people and the people I represent. I supported the creation and expansion of the State Children's Insurance Program, which increases access to health care for our nation's youth, and likewise the Family and Medical Leave Act, allowing employees to take time off from work to care for a sick and recovering family member.

However, I cannot support legislation that would threaten the sanctity of the patient-doctor relationship, that would establish new federal bureaucracies that would insert themselves into the health care programs of individuals and employers, that creates a new and financially unsustainable federal entitlement program, that threatens the availability of health care for our nation's seniors, that raises taxes substantially and threatens the viability of many small businesses at a time when we are trying to get our nation's economy back on track, and that ultimately will not make health care insurance more affordable for the American people.

We have all heard from the American people we represent over the past few months that this legislation has been under consideration. We have heard that they are closely following its progress. We have heard that they have many concerns about this legislation before us. And we have heard that they want us to work together in a bipartisan manner to bring down the cost and expand the availability of health care coverage.

Today, we have a historic opportunity to tell the American people we hear their voices. We can commit to them that, on this issue which will affect every single household and business in our nation, we will go back to our respective committees and work together—as Republicans and Democrats; conservatives, moderates and liberals; Blue Dogs and Progressives—to come up with a solution that the American people can support and, most importantly, have confidence knowing it will do the job without bankrupting our nation, jeopardizing our economic recovery and violating the free market principles upon which our nation was founded.

Mr. BARTON of Texas. Mr. Speaker, I yield a clock 3 minutes to the minority leader, Mr. BOEHNER. This is not his leadership imperial minute. It is the clock 3 minutes.

Mr. BOEHNER. Let me thank my colleague for yielding.

It will be no surprise to any of you that I rise in opposition to this bill.

One of the issues in this bill that is of concern to Members on both sides of the aisle has to do with the sanctity of life. The Rules Committee made in order an amendment by our colleague from Michigan (Mr. STUPAK) that would continue existing law that no Federal funds will be used for abortion.

While I am grateful that we're going to have this vote in the House, I want to ask the chairman of the Energy and Commerce Committee, Mr. WAXMAN, if the House does vote, in fact, for Mr. STUPAK's amendment, if the gentleman will guarantee me that when this bill

comes back from conference, that that language will remain in the bill.

Mr. WAXMAN. If the gentleman would yield.

Mr. BOEHNER. I would be happy to yield.

Mr. WAXMAN. As the gentleman well knows, the decision is not up to one person; it will be up to the conferees. The conferees will have to be meeting with the Senate conferees and going over a number of positions.

If this amendment is adopted by the House, it will be the House position as we go into conference. We will have to discuss it further, and then we will see what will be the result. But no guarantee can be made by me or any other Member at this time.

There will be an opportunity, as you know, to instruct the conferees, which reinforces, of course, a particular part of the House bill.

Mr. BOEHNER. Reclaiming my time, the reason that I rise at this point in the debate is that, while we are grateful to have this amendment and this chance to vote to make sure that taxpayer funding is not used for abortion—which has been the policy of the land for the last 30 years—as the gentleman pointed out, there is no guarantee that at the end of the day this language will be in the bill.

Now, I've been a chairman of a committee. I understand that there are no guarantees, but that's the whole point here. The only reason this amendment is allowed to be offered is in order to secure enough votes to try to move this bill through the floor today. I have my doubts about whether this language, if it passes, has any chance of ever being in the final version of this bill.

Mr. WAXMAN. Mr. Speaker, at this time, I am honored to yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), the chairman of the Health Subcommittee of the Energy and Commerce Committee.

Mr. PALLONE. Mr. Speaker, I want to thank my chairman, Mr. WAXMAN, for all his hard work on this bill.

For far too long, our Nation has endured a health care system that is chaotic, costly, and crippling American families. In casting our votes today, each of us must make a simple choice: Do we want to maintain the broken system we currently have or do we want to make it better?

And you should ask yourself, first, are you in favor of allowing health care premiums for American families to continue to spiral out of control, forcing them to delay care or drop coverage altogether, or are you in favor of providing every American with access to affordable and quality health insurance?

Second, are you in favor of more American families falling into bankruptcy under the weight of medical bills, or are you in favor of providing every American with the security of knowing that they won't go broke if they get sick?

Third, are you in favor of more American businesses delaying investments, closing their doors or laying off workers because of increasing health care costs, or are you in favor of making it more affordable for those businesses to provide health care coverage for their workers?

And finally, are you in favor of allowing health insurance companies to be able to discriminate against people because they are sick, women, or older, or are you in favor of putting an end to this explicit and immoral form of discrimination that insurance companies get away with today?

Mr. Speaker, there are many reasons to vote for this bill, but there is really only one reason to vote against it, and that is to maintain the broken health care system we currently have.

If you want to change the system, vote ''yes''; vote for affordable and quality health care for every American.

Mr. BARTON of Texas. I yield 2 minutes to a member of the Republican leadership, Mr. MCCARTHY of California.

Mr. MCCARTHY of California. I thank my friend for yielding.

Mr. Speaker, this is my second term. Since being elected by the people of California's 22nd District, I am reminded about how much things have changed.

Three years ago on this date, unemployment was 4.5 percent. Today, the unemployment rate has more than doubled to a 26-year high of 10.2. Three years ago on this date, the stock market was over 12,000. Today, the stock market has dropped by 2,000 points. Three years ago on this date the current House majority promised to drain the swamp. Today, the swamp in Washington isn't drained; it's overflowing. And 3 years ago on this date, November 7, 2006, the Democratic Party was victorious in winning control of this House.

Today, we are here on the floor to vote on a $1 trillion government takeover that can replace the health insurance that millions of Americans have. This is a defining vote for this Congress. We can reject tax increases on small business at a time when 2.8 million jobs have been lost since the stimulus was signed into law and say yes to helping small businesses access more affordable health insurance for their employees. We can reject the government takeover of our health care that will increase health insurance costs and say yes to saving American families up to $5,000 off their current health care premiums.

I know that over the last 3 years there have been many disappointments, when the voices of Americans have been overruled by government bailouts and now a government takeover of health care, but I urge my colleagues to reject the politics of the past and fight for a better direction for our country, for our children, and for our grandchildren.

I urge a ''no'' vote on H.R. 3962 and a ''yes'' vote for the Republican bill.

Mr. WAXMAN. Mr. Speaker, this bill reflects the input and the inspiration of two Kennedys in the Congress of the United States, certainly Senator Ted Kennedy, but also PATRICK KENNEDY, who has been such a leader in the areas of mental health and addiction.

I yield to the gentleman from Rhode Island for a unanimous consent request.

(Mr. KENNEDY asked and was given permission to revise and extend his remarks.)

Mr. KENNEDY. I rise in support of mental health benefits in this bill to support suicide, addiction, and depression coverage in this legislation for whole health coverage.

GENERAL LEAVE

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that Members have 5 legislative days in which to revise and extend their remarks on H.R. 3962 and include extraneous material in the RECORD.

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

There was no objection.

Mr. WAXMAN. Mr. Speaker, at this point, I am greatly honored to yield 3 minutes to the chairman of the Ways and Means Committee, one of the crafters of this bill and one of the great leaders in health care as well as other policy areas, the gentleman from New York (Mr. RANGEL).

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. We have an expression in my community, ''God is good,'' and basically it means that it gives us all an opportunity in our lives to do some of the things that we had hoped and dreamed would be possible. Since God has been good to our country and to this Congress, it means that we have a responsibility to extend our power to make certain that people have access to health care.

It's really surprising that the other side would believe that, as a party, their answer to this crisis that we face as a Nation in providing health care to so many millions of people that don't have it, that their answer is ''no'' and their vote will reflect ''no.'' But a short visit to history would see that every time we're talking about compassion—Social Security, Medicaid, and Medicare—their answer is going to be ''no.''

I want to thank our President for recognizing that even though we have to carry this load alone, it is an honor to be working under the leadership of Speaker NANCY PELOSI, our chairmen, Chairman WAXMAN and Chairman MILLER, and all of the wonderful people that have worked together under the caucus chair of Mr. LARSON so that we all would understand that we only have this one chance to get it right; Mr. CLYBURN, who brought our votes together so that we are able to be here on

this Saturday to pass this. But to me, most of all, it would be the hard-working members of my committee, men and women who worked day and night to make certain that we got out our initial bill and we also found a way to pay for it. And not only to make certain that this great Nation of ours would not have a deficit but, indeed, would decrease the deficit of this country by $100 billion over 10 years. And the staff, of course, of the Ways and Means Committee that serviced not just our committee, but all of the committees in the House and every Member who needed to know just how can we get this thing right and to do the right thing.

How proud we are that nobody is going to be denied health care because they had a preexisting condition before that. How proud we are that we don't have to select our jobs based on the health insurance that we have. And how proud we are that people who lose their jobs will not be losing their health coverage.

It is a small thing for some people like Members of Congress that already have their insurance, but for those of us that have the compassion to understand what it's like not to be able to take care of your family or your dear friends, not to be able to have health insurance, and for a Nation to be able to say that we are competing with industrial countries all over the world and they provide education and health care for their children, and this great country of ours, with all of the wealth, have to shamefully say that we can't afford to take care of our own people.

□ 1445

So, to those who don't understand what we're doing, this is going to be a historic day for you as well. Unfortunately, it won't be like it would be for us, because we can now have our names under Roosevelt's and under Obama's and under the right thing.

God is certainly good.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished ranking member of the Science Committee and a member of the Energy and Commerce Committee, the gentleman from Rockwall, Texas, Congressman RALPH HALL.

(Mr. HALL of Texas asked and was given permission to revise and extend his remarks.)

Mr. HALL of Texas. Mr. Speaker, I rise today to urge, of course, a ''no'' vote on the Democratic health care proposal.

I have five grandchildren, and already they will spend their entire lives paying the debts that we are accumulating. They will be in their late sixties before they are even paid. This bill is a generation killer, and the targets are your grandchildren and mine. My Fourth District of Texas is 100–1 against this bill, and I believe it's a good composite of other districts around the country.

I urge you all to please listen and to vote with your constituents, and I say to Members on both sides of this aisle: remember who sent you here, and vote their wishes. The American people have memories that will survive the actions of today's vote. They will not forget. I ask you to vote ''no.''

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from California, ANNA ESHOO.

Ms. ESHOO. Mr. Speaker, I come to the floor today to cast one of the most important votes of my congressional career, a vote for the Affordable Health Care for America Act. This effort is historic, almost a century in the making.

For many of us, this long battle has had a singular, courageous champion who fought like a lion for the sick, the elderly, the left behind, and the left out, Senator Edward Kennedy, and this bill is a fitting memorial to him.

Most uninsured Americans want to purchase health insurance, but they simply can't afford it. They are priced out. The middle class is priced out. Millions more live under the crushing weight of medical bills that bankrupt households or that shutter small businesses. This bill provides access to affordable health care for every American.

The abhorrent insurance practices of dropping sick patients to avoid paying expensive medical bills and discriminating against those with preexisting conditions will end with this legislation.

Very importantly, seniors, your Medicare will be strengthened; and it will provide you with better care.

I am proud to be part of making history. I think it is a privilege to do so. I urge all of my colleagues to vote for this legislation.

The SPEAKER pro tempore. The Chair will note that the gentleman from Texas has 28 minutes remaining, and the gentleman from California has 22½ minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the Energy and Commerce Committee, one of our ranking members of the subcommittee, the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. Mr. Speaker, I rise against this bill. I don't know if you saw the headline today in The Wall Street Journal: ''Grim Milestone as Jobless Rate Tops 10 percent.'' The New York Times: ''Jobless rate hits 10.2 percent with more unemployed. Official figure is highest since 1980. Broader measure stands at 17.5 percent.''

Mr. Speaker, I am from Michigan where our unemployment rate exceeds 15 percent. People want to work and pay taxes. They don't want to be laid off and receive benefits.

This 1,990-page bill is almost 20 pounds. Does anyone actually believe that spending another $1 trillion is going to reduce our unemployment? We add employer mandates. The Joint Committee on Taxation says that one-third of the $460 billion in taxes is going to be paid for by small businesses. How does that decrease our unemployment? It doesn't.

In closing, Mr. Speaker, let me say this: one of our colleagues today is quoted as saying: Health care costs are rising faster than wages and inflation, and this bill does not change that trend.

That was a Democrat and not a Republican who said it.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member of our committee, the gentleman from New York, ELIOT ENGEL.

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Affordable Health Care for Americans Act.

As a senior New Yorker on the Energy and Commerce Committee and on the Health Subcommittee, I am proud of the role I played in helping to make this bill a reality.

On this historic day, our Congress honors our country; it honors our citizens; and it honors a moral imperative to provide all Americans with comprehensive, affordable access to quality health care.

This is the reason why so many of us sought public office, and it is the reason why our constituents sent us to Congress, to right the wrongs of our broken health care system and to steer our country back in the right direction.

Never again will families worry late into the night over whether their preexisting medical conditions will prevent their loved ones from getting access to the health care coverage they so desperately need. Never again will insurance companies be allowed to drop coverage for those who have paid their premiums diligently only to have their policies canceled when they get sick and need it the most. Never again will families have to worry that, if they lose their jobs, they will also lose their health care coverage.

Don't believe the scare tactics you are hearing from the other side. This bill is good for seniors, good for young adults, and good for all Americans. I urge my colleagues to support the bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished former mayor of Fort Worth, Texas, the Honorable KAY GRANGER.

Ms. GRANGER. Mr. Speaker, unemployment is over 10 percent in this Nation. Our debt is nearly $12 trillion. Our deficit is $1.4 trillion.

Families are sitting at their kitchen tables trying to figure out how to pay their bills. Businesses have cut everything they can cut just to keep their doors open. Grandparents are taking in their kids and their grandkids.

We are going to vote another $1 trillion so government can take over our health care, cost those families more money, throw more mandates on our States, add 118 new departments and agencies to this already bloated Federal Government, take Medicare Advantage away from our seniors, let the health choices commissioner take the

place of our family doctors, mandate health insurance with jail for not complying with or for paying a tax, and ignore the voices of thousands of people who came here and who said, Listen to us. Don't pass this bill.

Mr. Speaker, what are people in this Chamber thinking of?

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member of our committee, the gentleman from Texas, GENE GREEN.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. This is a momentous day like that day in 1935 when Social Security was created and also like that day in 1965 when Medicare was passed.

We are in desperate need of health care reform. Health insurance premiums are growing three times as fast as wages; and, last year, more than half of Americans postponed medical care or skipped their medications because they couldn't afford them.

The 29th District in Texas, which I represent, has the highest number of uninsured individuals in the country as 40 percent of the residents are uninsured. If enacted, H.R. 3962 will provide coverage to 96 percent of all Americans and to 230,000 currently uninsured residents in our district. It will also improve the employer-based coverage for 217,000 residents in our district.

H.R. 3962 will give individuals the ability to access quality, affordable health insurance. They will no longer be denied coverage for preexisting conditions, and their coverage will not be capped or dropped when they are sick. The bill ensures no more co-pays for preventative care, no more yearly caps for what insurance companies will cover, and it provides premium subsidies for those who need it.

This is not government controlled medicine—individuals will be able to choose their own insurance plan and their physician.

This bill ensures individuals will be able to have access to primary and preventive care services so they will be able to see a doctor before they are sick, and be able to access quality medical services.

H.R. 3962 will rein in rising health costs for American families and small businesses—introducing competition that will drive premiums down, capping out-of-pocket spending.

The time for health reform has come and I urge my colleagues to vote in favor of H.R. 3962 not only for my constituents, but for all Americans.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to one of the distinguished ranking members of the Energy and Commerce Committee, the gentleman from Florida (Mr. CLIFF STEARNS).

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. I thank my colleague.

Mr. Speaker, I rise against this bill. The Congressional Budget Office has said that tort reform will save the Federal Government $54 billion. Instead, we get a bill today that makes a mockery of tort reform.

The Democrats add a provision that will clearly increase costs for health care and that will make it harder to recruit doctors. The new language explicitly prevents States who accept these grant funds from capping noneconomic damages or attorneys' fees even if it is current law.

Said another way, the Secretary of Health and Human Services can give such sums as he deems necessary to any States that do not cap attorneys' fees, or said another way, the bill undoes all States' tort reform.

This bill violates States' rights. It undermines their efforts at real tort reform. It allows trial lawyers to begin open season on our doctors and medical providers.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a very active and important member of the Health Subcommittee and of the full Energy and Commerce Committee, my colleague from California, LOIS CAPPS.

Mrs. CAPPS. Mr. Speaker, I am honored to rise in emphatic support of H.R. 3962. As we pass this historic legislation today which improves health care for all Americans, I want to focus on the benefits for women's health.

When this bill becomes law, a woman will no longer be discriminated against by an insurance company simply for being a woman. Women will no longer be discriminated against by insurance companies for being victims of domestic violence. Women will automatically be covered for maternity care. Women will not have to pay co-pays for important preventative screenings, like mammograms and cervical cancer. Most importantly, women who make the bulk of the health care decisions for their families will have access to quality, affordable health care for their families.

This is an excellent bill, and I am humbled by the fact that, as a Representative of the 23rd Congressional District in California—a nurse, a mother and a grandmother—I am privileged to vote today in favor of this bill. I urge all of my colleagues to do the same.

Mr. BARTON of Texas. I yield 1 minute to another of my distinguished ranking members on the Energy and Commerce Committee, the gentleman from the Bluegrass State of Kentucky (Mr. WHITFIELD).

Mr. WHITFIELD. Mr. Speaker, there are many provisions of this 2,000-page Affordable Health Care for America Act that we can support on this side.

Yet we do not support the establishment of a Federal health care board to control health care in America. We do not support establishing civil penalties of up to $10,000 a day for violating health regulations. We do not support reducing Medicare funding by $500 billion. We do not support cutting funding for hospitals by $155 billion and rural hospitals by $6 billion between 2017–2019. We do not support increasing taxes on small business owners, particularly at a time when we have an unemployment rate of 10.2 percent.

If we had a surplus, we could support spending billions of dollars for the sovereign states of Micronesia, the Marshall Islands and Pulau. Since we have a $11 trillion debt, why should we be spending money for health care in those countries? We are also increasing by $10 billion health care for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. DOYLE).

□ 1500

Mr. DOYLE. Mr. Speaker, my colleagues on the other side of the aisle are trying to scare our seniors. They are telling tall tales, saying that passing health care reform will destroy Medicare.

For Americans watching this debate, I want to make this clear: This bill will strengthen Medicare. My good friend from Michigan, JOHN DINGELL, helped write the law that created Medicare, and he authored this health care reform bill we will vote on today.

This bill protects seniors and gives all Americans access to quality, affordable health insurance. This bill will start to close the Medicare prescription drug doughnut hole and ban insurance companies from dropping people for having the audacity to get sick. This bill makes sure that preventive services are free to seniors in Medicare and all Americans with insurance.

This bill extends the Medicare's solvency by at least 5 years, it pays for itself and it will reduce the national debt. Finally, this bill is endorsed by doctors, nurses, patients, the Autism Society of America and the AARP.

Mr. BARTON of Texas. I would like to yield 1 minute to the gentlelady who has the privilege of representing Key West, Florida, the Honorable ILEANA ROS-LEHTINEN.

Ms. ROS-LEHTINEN. Mr. Speaker, I am blessed that even though my elderly mother has Alzheimer's, we are able to provide her with high quality health care, but I am worried.

I am worried about the families who, like mine, have an elderly parent who needs care and assistance. It's not easy for any family to support a loved one through hard times, and there is no doubt that these are hard times.

Unemployment in my area of south Florida is over 11 percent. In the midst of this, the Pelosi bill takes away from seniors. Yes, it does. The Pelosi bill makes $170 billion in cuts to Medicare Advantage, causing 3 million seniors to lose their current coverage. The Pelosi bill will increase Medicare prescription drug premiums by over 20 percent, a rate unaffordable to most seniors.

When I see my mother, I know that health care reform should not occur at the expense of America's seniors. Reject the Pelosi sock-it-to-the-seniors plan.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from the

State of Washington, a very important member of the Energy and Commerce Committee, Mr. INSLEE.

Mr. INSLEE. Mr. Speaker, I just want to relate one call from a small businessman who told me we needed health care reform so that his wife can finally start a small business of her own and be freed from the insurance industry that stopped her from getting insurance.

I would like to enter into a colloquy with Mr. WAXMAN.

Mr. Chairman, I would like to clarify section 1188, the generic fill provision in the bill. This section allows Medicare part D plans to waive patient's copays for generic, bioequivalent and biosimilar drugs. I believe that absent explicit approval from the patient's doctor, this inducement should only apply to those biosimilars that have been rated ''interchangeable'' by the FDA, meaning that they can be expected to produce the same clinical result in any given patient and switching medicines poses no greater risk than not switching. With respect to biosimilars that have not been rated as interchangeable, is it your intent that under this provision patients could not be switched to a non-interchangeable biosimilar drug without an explicit request by a patient and approval by their doctor?

Mr. WAXMAN. Congressman INSLEE, you are correct. It's our intent that the patient would not be switched from a referenced product to a non-interchangeable biosimilar without approval from the doctor.

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

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

Our intent is also that a patient could not be financially induced by their plan to switch to a non-interchangeable biosimilar without the consent of their doctor, and I am happy to work with the gentleman to clarify the language in conference.

Mr. INSLEE. Today we should pass this bill.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 2 minutes now to the leader of the Republican Health Care Task Force and a member of our committee, the deputy ranking member, Mr. ROY BLUNT.

Mr. BLUNT. Thank you, Mr. BARTON.

Mr. Speaker, there are so many things that I am for in health care. In our Health Care Solutions Group, I am sponsoring a dozen bills. The core of those bills we will talk about later when we get to the Republican substitute.

But if those bills cost $1.1 trillion, the bills I am for, I would be against those bills. We can't afford this bill. It cuts Medicare $505 billion. It raises taxes.

There is no estimate I see of people who have estimated the job impact who don't say that it cuts jobs. Instead, it's a 2,000-page roadmap to a government takeover of health care.

We could be here today talking about real reforms, medical liability reform, access for everybody regardless of preexisting conditions. We think you can do that by expanding a risk pool concept. It costs a little money, but it doesn't cost billions and billions and billions of dollars.

If we could find Medicare savings, Mr. Speaker, we should use those Medicare savings to save Medicare. Only the government would have made a commitment to a program like Medicare, know that program is in huge trouble beginning in about 2017, and be here today saying we should make savings from that program to fund a new program. If there are savings in Medicare, we should be using them to save Medicare, Mr. Speaker.

I hope we reject this bill. Even if this bill passes today and doesn't go further than this, I hope we can work together to do the things we really need to do to reform the system.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentleman from the State of North Carolina, an important member of our committee, Mr. BUTTERFIELD.

Mr. BUTTERFIELD. I thank the gentleman for yielding the time.

Mr. Speaker, later today we will have an opportunity to fix a broken health care system. I have listened to both sides of this debate, I have read everything available, and I have prayed for guidance.

We have an obligation, constitutional and moral, to provide for the general welfare of every American citizen. Allowing a broken health care system to continue to bankrupt families, businesses and hospitals and deny coverage to millions is a failure of duty.

We must act now. Reject the false rhetoric surrounding this debate. Reject the false claims about Medicare coverage reductions. The bill strengthens Medicare. Reject the false rhetoric about government-run health care. The bill provides healthy and needed competition.

Reject the claim that this legislation will increase the debt. Doing nothing will increase the debt by billions. We should not delay any longer.

I urge my colleagues to vote ''yes'' on this legislation.

Mr. BARTON of Texas. Mr. Speaker, I see that we have changed from the Jets and the Giants to the Green Bay Packers in the chair.

I would like to yield 1 minute to a Ramblin' Wreck from Georgia Tech, a member of the Committee on Energy and Commerce, Dr. GINGREY.

Mr. GINGREY of Georgia. Mr. Speaker, having spent most of my life in medicine and healing the sick, I rise in strong opposition to this bill. With double-digit unemployment at 10.2 percent, this so-called reform, which will destroy an additional 5.5 million jobs, is not what the American people want. Yet their opposition and protests have fallen on deaf ears as this majority simply does not seem to care.

One can perhaps see why. Democrats have the White House, 60 votes in the Senate and an 81-seat majority in this House. They have all the power. They can pass government-run health care without one single Republican vote. Mr. Speaker, just because they can does not mean they should. Might does not make it right. With $750 billion in tax increases, $500 billion cuts in Medicare, Mr. Speaker, if the House proceeds down this precarious path, I have no doubt that though the American people may forget what was said here, they will never forget what was done here and who did it to them.

Mr. WAXMAN. Mr. Speaker, I yield for the purpose of a colloquy to the chairman of the subcommittee, Mr. PALLONE, 1 minute.

Mr. PALLONE. Thank you, Chairman WAXMAN.

The bill we are debating today includes the CLASS Act, a bill I sponsored, along with Representative DINGELL, which would encourage individuals to plan ahead for future long-term care needs. But there are other things we can do to help increase the availability of home and community-based services. The Empowered at Home Act, H.R. 2688, which I sponsored with Representative DEGETTE, helps encourage States to improve and increase access to home and community-based services under their Medicaid programs.

While we were not able to include these other provisions from the Empowered at Home Act in H.R. 3962, I hope that we can consider their inclusion in the final health reform bill that emerges from the conference with our Senate colleagues.

Mr. WAXMAN. I want to thank the gentleman from New Jersey for his leadership on the bill before us today and for his tireless efforts on behalf of low-income Americans who need long-term care. I support the elimination of barriers to the provision of home and community-based services under Medicaid, a result that the gentleman's Empowered at Home Act would achieve.

The SPEAKER pro tempore (Mr. OBEY). The time of the gentleman has expired.

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

I will continue to work with you and other Members to enact legislation that gives State Medicaid programs a robust option for offering low-income Americans the choice of receiving long-term care services in the community rather than in a nursing home.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentlewoman from Missouri, who represents the hometown of Rush Limbaugh, Cape Girardeau, Missouri, Congresswoman JO ANN EMERSON.

Mrs. EMERSON. Mr. Speaker, this could have been a great day in the House of Representatives, but we have missed an opportunity for consensus, to improve access and save money for

taxpayers and patients alike. Americans pay the highest prices for prescription drugs in the world and this bill binds us to that fate.

For every Member of Congress, there are two and a half pharmaceutical lobbyists. In the first half of 2009, drug companies spent $609,000 every day on lobbying. We have missed an opportunity to tell the drug companies that they no longer set the agenda in Congress.

We have missed an opportunity to put the interests of Americans ahead of special interests. We have missed an opportunity to end the pill-splitting, skipped doses and unfilled prescriptions that plague Americans who can't afford the medicine their doctor prescribes.

This bill shifts those costs from patients to taxpayers, from this generation to the next. It trades affordable generics for pricey name-brand name drugs. It intentionally makes quality care more expensive for our Nation, and it is wrong to leave hundreds of billions in savings on the table.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to a very important member of our committee, the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Speaker, as a family physician who practiced for more than 20 years, a mother, a grandmother and an American, I am proud to stand here in support of the Affordable Health Care for America Act. This bill is for the many patients I know who put off health care until it was too late because they couldn't afford it and the tens of millions like them who will now have access to full health care.

This year and every year past, over 80,000 African Americans died, whose deaths were preventable, because they were unable to get health care. This bill is for all people of color, those in our rural areas, the territories and the poor, because beyond insurance, this bill will provide the services some of them never had.

H.R. 3962 will give young people for whom a health care professional is out of the reach the opportunity to help heal their communities. It will cover 36 million uninsured people, making insurance secure and affordable, strengthen prevention and public health, improve Medicare and Medicaid, help poor communities, create an environment that supports good health, and finally begin to eliminate health disparities.

Today we have the opportunity to vote for health and a better life for everyone in this country and for a better country where life, liberty and the pursuit of happiness is truly a right for all.

Let's make history together. Vote ''yes'' for affordable health care for America.

Mr. BARTON of Texas. Mr. Speaker, I recognize one of my ranking subcommittee members, Mr. RADANOVICH, who represents Fresno, California, for 1 minute.

Mr. RADANOVICH. Mr. Speaker, we are standing on the precipice of a major shift in this country's history. In less than a year, the Obama administration, working with the Pelosi Congress, has recklessly spent taxpayer funds to expand government to a level never before seen in history.

The government is now more involved in our lives than I think any of us could have imagined. The result has been double-digit unemployment for the first time since the early 1980s. And now we are going to vote on whether the government should take over the Nation's health care system at a cost of $1.3 trillion and up to 5.5 million jobs.

Despite all this, the leadership of this Congress has chosen to ignore the will of the people and say, America, you are wrong. We know what's best for you.

Well, this bill is not what the American people want, and it certainly is not what the doctor ordered for health care improvement.

□ 1515

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY), a senior member of the Energy and Commerce Committee.

Ms. SCHAKOWSKY. This is a great moment in history because today we act to guarantee affordable health care for this and future generations. It is a great day for women. Our bill stops gender rating, preventing insurance companies from charging women 48 percent more than men for the same coverage.

We eliminate preexisting conditions. Being a breast cancer survivor or domestic violence victim will no longer prevent access to care. We require coverage of maternity and well-baby care. We ensure that older women not yet eligible for Medicare can buy affordable coverage.

We improve Medicare. Senior women will be able to afford preventive services like cancer screenings because we eliminate cost-sharing. We close the doughnut hole, so they can afford their medications.

Women need health care reform. They need H.R. 3962.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the honorable gentlewoman from North Carolina (Mrs. MYRICK), a cancer survivor.

Mrs. MYRICK. Mr. Speaker, Americans are struggling with health care costs. We all know that. Too many families can't afford coverage, and small businesses are struggling to find coverage for their employees.

However, this bill does not fix the underlying problem, the cost of health insurance. It is an unprecedented expansion of Federal Government spending that will only dig a deeper hole of debt for generations to come.

Margaret Thatcher once said, ''We want a society in which we are free to make choices, to make mistakes, to be generous and compassionate. Not a society in which the State is responsible for everything, and no one is responsible for the State.''

The majority's bill creates a society that resembles the latter, and it is a mistake. I urge my colleagues to vote ''no.''

Mr. WAXMAN. Mr. Speaker, can I inquire how much time is available on each side?

The SPEAKER pro tempore. The gentleman from California has 13½ minutes remaining. The gentleman from Texas has 17½ minutes remaining.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Speaker, I rise in support of this bill, which will provide affordable health coverage to 36 million people who lack it today. This has been an aspiration for our Nation and our people for decades.

I first ran for office motivated by my belief that every American should have access to quality health care, and I will not stop fighting until every American is covered. There are far too many daily reminders of the failures and injustices of our current system, the countless stories of bankruptcy, care delayed and premature death. And yet we have let years go by while people suffer.

Today, we convene to debate and advance legislation that delivers meaningful insurance reform, outlawing outrageous insurance abuses, lowering costs, and extending coverage to all. I will cast my vote today on behalf of the people in Wisconsin and millions throughout America who have said enough is enough.

Today, we declare with conviction: every American deserves health care, and every American shall have it.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the sixth Frelinghuysen to represent a district from the Garden State of New Jersey, the Honorable RODNEY FRELINGHUYSEN.

(Mr. FRELINGHUYSEN asked and was given permission to revise and extend his remarks.)

Mr. FRELINGHUYSEN. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise in opposition to this legislation because I have been listening to my constituents. Over the past several months, I have received over 13,000 letters, emails, faxes and calls from New Jersey families and employers. Unprecedented. I have listened to hundreds of residents in town hall meetings, retirement communities, nursing homes and senior clubs.

I have visited areas hospitals and businesses, large and small. I have met with medical societies, health providers, doctors, nurses, anesthesiologists, home health aides, chiropractors, surgeons, all of them.

In each of these meetings, these men and women have expressed deep concern about the so-called health care reforms that have been sponsored by the House majority, the Pelosi bill, and most are opposed. They are worried about how this massive bill, over 1,900 pages long, will affect their doctor-patient relationship, their personal care, and their ability to afford their health insurance. And they are worried with good reason.

H.R. 3962 is a toxic-mixture of job-killing higher taxes, rampant new mandates on businesses and individuals of all ages and damaging Medicare cuts, combined with a government takeover of health care.

It demands opposition on so many grounds:

First, according to the Congressional Budget Office, H.R. 3962 will cost at least $1.2 trillion over the next ten years! This is mind-boggling, on top of earlier borrowing and deficits!

To pay for this massive new spending, Speaker PELOSI wants to raise taxes and cut Medicare that older Americans depend on each and every day.

My colleagues, we heard the grim news yesterday that unemployment currently is at a 26-year high—10.2 percent. (And we know it's actually higher.) And yet, this bill contains $735 billion in new taxes!

Using the formula developed by the chief White House economic advisor, 5.5 million Americans could lose their jobs as a result of enactment of the Pelosi Health Care bill.

$735 billion in new taxes.

Among the new taxes is a new "surtax" on high-income filers—many of whom are small business men and women.

While this tax is intended to target "high-income" individuals and couples, it is not indexed for inflation, meaning it will reach millions more New Jersey residents over time just like the Alternative Minimum Tax.

H.R. 3962 also includes taxes on individuals who do not purchase government-mandated health insurance.

Think about this! You do not make enough money to afford health insurance and this bill actually fines you! The end result: you still don't have coverage and you've been fined as well!

Young people will be particularly surprised that they will be subject to such a fine!

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentleman from Massachusetts (Mr. FRANK) for the purpose of a colloquy.

Mr. FRANK of Massachusetts. I thank the chairman, and I congratulate him for the excellent work he and others have done on this bill.

I want to discuss the importance of the bill in addressing hard-to-reach communities, including commercial fishermen, who are a very important part of my constituency, but also farmers and ranchers. Ranchers tend to be a less important part of my constituency.

We are creating a new health insurance marketplace and requiring everyone to have coverage, which I support. This makes it particularly important to educate those that haven't had reliable, continuous access to quality, affordable health care.

Under the bill, will the commissioner be able to contract with entities such as commercial fishing organizations or others to facilitate the dissemination of information?

Mr. WAXMAN. The answer is yes.

Mr. FRANK of Massachusetts. I thank the gentleman. I assume this means also the commissioner can work with the Small Business Administration on this sort of outreach and education?

Mr. WAXMAN. Yes. The bill ensures the commissioner will work with the Small Business Administration.

Mr. FRANK of Massachusetts. I thank the chairman for clarifying these points.

Section 2229 of the Senate bill recognizes the unique health care educational outreach needs of commercial fishermen, farmers and ranchers, and I hope that that will be accepted in the final bill.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the honorable gentleman from Pennsylvania (Mr. PITTS), one of the strong pro-life leaders in the U.S. Congress, a combat veteran of Vietnam, and a member of the Energy and Commerce Committee.

Mr. PITTS. Mr. Speaker, there has been some recent confusion surrounding the inclusion of abortion coverage in H.R. 3962, but the issue is actually quite clear. The Capps amendment in the bill, which some have argued is neutral on abortion, explicitly authorizes the Federal Government to directly fund elective abortions using Federal funds drawn from a Federal Treasury account. The provision has been billed as a so-called compromise amendment. But this bill will radically expand current and longstanding Federal policy with respect to abortion.

Currently, there is not a single government health care program that provides coverage for elective abortion; not SCHIP, not Medicaid, not DOD, Indian Health or the Federal Employee Health Benefit Program, all because of congressional action to explicitly prohibit coverage of abortion under each of these programs. But such an explicit exclusion is missing from this bill.

Therefore, I urge my colleagues to support, when it comes up later, the Stupak-Pitts-Chris Smith-Ellsworth-Dahlkemper-Kaptur amendment that would prevent Federal funding of abortion in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. CASTOR), a member of our committee.

Ms. CASTOR of Florida. Mr. Speaker, Democrats will now deliver on what American families and businesses have been asking for when it comes to their health: one, meaningful, secure and stable insurance; two, improved Medicare for seniors; and, three, vital consumer protections.

For families with health insurance, health reform will provide you with coverage you can count on. Families will no longer have to worry about insurance companies canceling their coverage because someone in their family gets sick. Health insurance companies will no longer be able to bar you from insurance just because you have diabetes or cancer or some other chronic condition.

American families have been doing everything right. They have been paying their copays and paying their premiums, even as those costs have risen dramatically. Our health bill says that in return, that coverage must be meaningful, stable and secure. And for our family members who rely on Medicare, you will see immediate improvements, in your prescriptions, your checkups, and a provision I worked on, to penalize unscrupulous practices of private Medicare insurance sales agents.

The meaningful health reform that will pass the House today builds on the great legacies of Social Security and Medicare, and I am proud to represent Florida families in this historic vote.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentlewoman from Wyoming (Mrs. LUMMIS), who represents the entire State.

Mrs. LUMMIS. Mr. Speaker, I stand before you today on behalf of the people of Wyoming, where individual freedom and personal responsibility are hallmark values.

This $1 trillion tax-everybody-right-down-to-the-wheelchair debacle will impact every person in Wyoming. This bill will force my constituents to buy insurance, whether it makes sense for them or not. This bill will dump some of my constituents into a government-run health care program to which Members of Congress will not even subject themselves.

I sought an amendment that would allow States to shield their citizens from government-forced insurance, from taxes and possible fines or imprisonment, from government policies that come between themselves and their doctors, from unfunded mandates on States. But my amendment and dozens of others were swept away by the majority, and American freedoms right along with it.

Our Constitution was designed to empower the American people and shackle the Federal Government. This bill will shackle the American people while empowering the Federal Government. It is a sad day for Wyoming, Mr. Speaker.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. PATRICK J. MURPHY), who has been a leader in our efforts to lower growth in premiums through measures such as immediate review and justification of insurance rate increases.

Mr. PATRICK J. MURPHY of Pennsylvania. Colleagues, voting ''yes''

today means tax incentives for Joe Frederick, a small business owner in Bucks County, Pennsylvania, who struggles with skyrocketing health care costs for his employees. It is a vote for Mrs. St. Clair, whose niece died because she couldn't get insurance. It is a vote for Jay Doroshow, who was kicked off his plan after being diagnosed with Lou Gehrig's disease.

I urge a ''yes'' vote for our fellow Americans who want to secure affordable health insurance which can't be taken away from them when they need it most.

Sixteen years have passed since we last tried to reform health care. Premiums have more than doubled. Every day in the State of Pennsylvania, 510 families are kicked off their coverage. That is every single day.

Mr. Speaker, as I said, I am a proud Blue Dog Democrat, and there is universal agreement that to get our country's fiscal house back in order, we must first get our health care spending under control. And this bill does just that. It actually reduces our deficit by $129 billion, taking important steps to rein in health care costs.

But there is more work to be done, and I look forward to working with you and our leadership to accomplish this goal.

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

Mr. WAXMAN. Mr. Speaker, I yield the gentleman an additional 10 seconds.

If the gentleman would permit, I want to thank you for your leadership, and assure you we are going to continue to work in conference to do everything we can to make coverage affordable for the American people.

Mr. PATRICK J. MURPHY of Pennsylvania. Thank you, and I urge my colleagues to vote ''yes'' today.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Nebraska (Mr. TERRY), who represents Omaha, Nebraska, the home of the College World Series.

Mr. TERRY. Mr. Speaker, it is clear that skyrocketing health care costs do exist, causing a number of Americans to become uninsured. But instead of addressing these issues, the Speaker has offered us a bill that dramatically overhauls the present health care system.

It injects government into every corner of health care decision-making, from arming the Health Choices Commissioner with unprecedented power to dictate coverage and influence costs, to imposing crushing taxes on small businesses. It transfers $600 billion from Medicare and Medicaid and imposes mandates on States by expanding Medicaid, which will then trickle down and force the States and the localities to increase taxes, really masking the true cost of this massive $1.2 trillion bill.

There is a better way that we can accomplish providing Americans with affordable health care.

□ 1530

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Connecticut (Mr. MURPHY).

Mr. MURPHY of Connecticut. Mr. Speaker, every night in my State, thousands of kids go to sleep sick in their beds just because their mothers can't afford to get them to doctors. This is the most affluent, most compassionate Nation in the world, and it makes absolutely no sense that our health care system is the most inefficient, most unfair in the world. But to change this, we don't need to throw out what we've got.

Despite all this nonsense political speak from the Republicans about government takeovers, this bill simply seeks to reset the rules of the private health care marketplace so that it starts working again like it should, so that small businesses can band together to negotiate for lower prices, so that individuals will have access to tax credits to help them pay for private insurance, insurance that's fair and doesn't discriminate against them because they're sick. We'll fix this crisis in our health care system all on the shoulders of a reformed private system so that never again does a child fall asleep sick in his bed because his country, the most powerful in the world, didn't have the coverage to make him well.

Mr. BARTON of Texas. I would like to recognize the gentleman from Virginia, Congressman FRANK WOLF, for a unanimous consent request.

(Mr. WOLF asked and was given permission to revise and extend his remarks.)

Mr. WOLF. I rise in strong opposition to the bill because our Nation is going broke.

I rise in opposition to this bill.

We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in entitlement obligations.

I am also deeply concerned about the national debt, which has doubled since 2000 and is nearing $12 trillion for the first time in our history.

Any plan put forward must control costs, not add billions of dollars to an already ballooning deficit.

America is going broke. Is this the legacy this Congress wants to leave our children and grandchildren?

NEWS RELEASE

''Health care is a very personal issue and there are very real consequences to what Congress does on this issue. Congress must be committed to offering affordable, accessible, and portable health care choices with the goal of fixing what's broken and keeping what works. I know there are good and reasonable people with deeply held views on every side of the health care reform issue. That's why I believe all sides need an opportunity to be heard and offer ideas so that a bipartisan consensus can be reached.

''I believe every fair-minded person would agree that Congress needs to find a way for the millions of Americans without health insurance to be assured of quality, affordable health care when they need it and to address the concerns of those who are paying for a plan they believe falls short of the coverage they need. Part and parcel of that discussion, I believe, also must be the recognition that there are many folks are paying for a health insurance plan that they like and want to keep and they don't want the government involved in their health care decisions.

''I am very concerned, however, about the health care reform process under way in Congress. House Democrats on October 29 unveiled a 1,990-page health reform bill—H.R. 3962—which is estimated to cost just under $900 billion over 10 years. Especially troubling is the majority leadership's intention to fast track the legislation for House consideration within days of its introduction.

''Congress needs to listen to the American people, take its time and get health care reform legislation right. This is too important an issue to rush through under some artificial timeline. It is for this reason that I am cosponsoring a resolution calling for any health care reform legislation considered by Congress to be made available online in its final form 30 days prior to being voted on in the House. I believe that every American must have the opportunity to read and understand what Congress is considering. Now with the latest bill covering nearly 2,000 pages, that is more important than ever. A copy of H.R. 3962 is available on my Web page, www.wolf.house.gov.

''I opposed the first version of the Democrats' health reform legislation (H.R. 3200) that was introduced this summer, and nothing that I have read so far in the newest version introduced on October 29 changes my view. This legislation would set up a government insurance option with rates to be negotiated between providers and federal health officials. It has mandates for every American to have insurance and for employers to provide insurance. It would expand Medicaid to historic levels adding new mandates on states. The revenue sources identified include a surcharge on wealthy taxpayers and changes to Medicaid and Medicare which would translate to about $500 billion in cost savings over 10 years, according to the Congressional Budget Office.

''When President Obama earlier this year directed Congress to come up with a health reform plan, I had hoped that both Republicans and Democrats could work together on this issue of such complexity in a bipartisan way and reach consensus on a plan to address the needs of uninsured Americans, protect those with insurance plans they like, and keep a lid on deficit spending at a time when our economy is reeling from recession and spiking unemployment. What we have seen, however, is the opposite. The speaker and House majority worked alone on H.R. 3200 that initially was to be voted on by the House in early August. They have continued to work behind closed doors to refine that plan, and the latest bill, H.R. 3962, was drafted solely by the majority.

''I don't believe that is the right way to develop public policy on an issue of such importance and far-reaching consequence to every American. This is a complex issue to legislate, and there are legitimate questions that Congress must answer. Among the many questions to be resolved are how to make sure health care decisions are patient-centered and remain between physicians and patients and not prescribed by some government formula; how to provide for Americans who don't have health insurance and ensure those with pre-existing conditions can get insurance; how to protect those who have health insurance and don't want to be forced to give up their plans or pay more for them; how to control health care costs and pay for health care reform without increasing the

deficit; how to ensure that U.S. taxpayers are not subsidizing health insurance for those illegally in our country; how to ensure that the self-employed and small business owners can afford insurance, and how to ensure that young adults can continue to be carried under their parents' health plan until they reach age 25.

''I have concerns about a government-run insurance option and what that will mean in the way of costly mandates for small businesses and other employers during a time when unemployment is teetering near 10 percent. I am also concerned about how Americans will pay for a $900 billion plan as our country tries to work its way out of an economic recession and faces trillions of dollars in debt and a growing annual deficit that could be near $2 trillion. I also have questions about finding a half trillion dollars in savings in Medicare and Medicaid costs. What will that mean for senior citizens today?

''We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in promised entitlement obligations through Medicare and Social Security. I'm also concerned about the national debt, which has doubled since 2000 and is nearing $12 trillion for the first time in our history, and unprecedented federal deficits, which could result in increased interest rates for consumers if we continue to finance government by borrowing from foreign lenders. I have the leading bill in the House to establish a bipartisan commission to review entitlement spending with tax policy on the table to ensure that Congress addresses these spending issues, which if left unchecked, will be disastrous for future generations. (For more information about the SAFE commission, go to www.wolf.house.gov/SAFE.)

''I again want to emphasize: it is important for Congress to fix what's broken with our nation's health insurance system. But we have to do it the right way without changing what is working. We need a plan that controls costs without adding billions of dollars to an already ballooning deficit; ensures competition and choice; provides that patients and their doctors make the decisions on medical care rather than a government-run agency, and addresses skyrocketing medical liability costs and tort reform.

''I believe that the legislation in the House falls short of those goals and that Congress has a lot more work to do to provide the kind of health reforms Americans want and need.''

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the former FBI man from the great State of Michigan (Mr. ROGERS), a member of the committee.

Mr. ROGERS of Michigan. Mr. Speaker, there are huge consequences to the 85 percent of Americans who have earned their health care in this bill. Not only will they get longer wait times and more expensive premiums, but at the end of that, with new debts, some $1.5 trillion in new spending, 18 million Americans won't have coverage. But more importantly, there will be another victim.

There is nothing more sacred than the bond between a mother and a child, that trust, that love, that nurturing when that child is sick. And when a mother goes to the doctor under that 2,000-page bill, that relationship that they enjoy between their patient and their doctor and what that mother wants for that child is no longer sacred, because now, through the 118 different boards and commissions, their comparative effectiveness research allows the Federal Government, through forced government insurance, to ration and deny care. You have violated the most important trust, the most important thing that we have in the building block and the foundation of the values of this country. That mother, that doctor knows what's best for that child. You will find no compassion in a Federal bureaucracy.

Mr. Speaker, I would urge the strong rejection and the protection of that bond between doctor and patient and mother and child.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Colorado (Mr. SALAZAR).

Mr. SALAZAR. Mr. Speaker, I am especially pleased that this bill will help rural America. Currently, physicians in rural areas are reimbursed less from Medicare than their urban counterparts. H.R. 3962 will reimburse primary care physicians in rural areas 10 percent more than the urban physicians not only to equalize the disparity, but to make rural communities more attractive to physicians.

Most of my district is considered a health professional shortage area. In my district in Colorado, we have three counties with only one practicing physician. We have one county with none at all. This bill will increase the number of physicians in all of my counties and improve access for 106,000 Medicare beneficiaries.

This bill will expand insurance coverage to 111,000 currently uninsured residents in my district. In my district, it will protect 900 families from going bankrupt due to excessive health care costs. It will help 184,000 low-income families pay for their insurance.

Our current system is broken, and it is time to fix it now.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from the Pelican State, Congressman SCALISE from New Orleans, a member of the committee.

Mr. SCALISE. I want to thank the ranking member from Texas for yielding.

I rise in opposition to Speaker PELOSI's 1,990-page government takeover of health care. Weighing in at nearly 20 pounds, this bill comes out to over $530 million of spending per page. And where does this bill spend that money? Well, first of all, it fails the American people. It fails those small businesses and families that are going to have to pay the $730 billion in new taxes in this bill. It fails our seniors who have to deal with over $500 billion in cuts to Medicare. And it fails many of President Obama's own pledges and promises he made right here on this floor, like when he said, If you make less than $250,000 a year, you won't pay any new taxes, ''not a dime.''

In this bill, there is over $20 billion of new taxes just on people who have no insurance. The President has said multiple times, If you like what you have, you can keep it. Unfortunately, this bill fails the President's promise because it allows the health care czar to take away your insurance even if you like it. It's so bad, that even when we brought our amendment to say all Members of Congress have to abide by this bill, they actually refused to allow a vote on that amendment.

We need to defeat this legislation and do real reform.

The SPEAKER pro tempore. The Chair would announce that the gentleman from Texas has 11½ minutes remaining, and the gentleman from California has 6¼ minutes.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Ohio, BETTY SUTTON, a member of our committee.

Ms. SUTTON. Mr. Speaker, the American people have been waiting for this day, a day that we will finally pass a health care bill that will work for and with them, that will provide them with access to more affordable quality care, care that they can count on.

Mr. Speaker, they have been waiting for us to put an end to the egregious discriminatory practices of insurance companies who deny coverage based on preexisting conditions and place caps on coverage to prevent people from accessing the care they need just when they need it the most.

Today we act to improve the employer-based coverage for 420,000 residents in my district, to improve Medicare for 107,000 beneficiaries, and to move to close the prescription drug doughnut hole for seniors across this country.

Yes, Mr. Speaker, the American people have been waiting, and today we act for a health care system that will work for and with them.

Mr. BARTON of Texas. Mr. Speaker, could I ask how much time. You said it a minute ago, but I was not listening.

The SPEAKER pro tempore. The gentleman from Texas has 11½ minutes remaining. The gentleman from California has 5¼ minutes remaining.

Mr. BARTON of Texas. Thank you, Mr. Speaker. I was listening to my distinguished friends on the majority raptly.

I now yield 1 minute to one of our doctors, physicians, the gentleman from Lewisville, Texas, the Honorable MICHAEL BURGESS, also a member of the committee.

Mr. BURGESS. I thank the gentleman for yielding.

Last spring and summer, as we got into this debate, America's doctors were pretty clear of what they wanted to see if Congress was going to undertake health care reform. They wanted to see some relief in the medical justice system. They wanted to see some medical liability reform. They desperately needed a fix to the payment formula in Medicare that shows reductions in Medicare reimbursement rates every year for as far as the eye could see, and they wanted a little help with

antitrust relief. After all, if we're going to ask our doctors to be our partners in this brave new world of health care reform, the least we could do is let them talk amongst themselves about the best way to deliver high-quality care at low cost.

Well, what happened? Antitrust; not in this bill. SGR; we'll take that up at some point in the future. Medical liability; a smidgeon of medical liability reform in this bill, but nothing compared to what doctors actually need.

In the last 6 years, Texas has done what this country needs to realize would be the way forward in medical liability reform. Caps on noneconomic damages have worked in the State of Texas. You don't have to take my word for it. There are almost 15,000 new physicians that have come to the State of Texas since 2003 when this was enacted. There are 82 counties that now have doctors which did not have them before. Emergency room services and OB services particularly have seen significant increases since Texas passed their sensible liability reform.

Mr. WAXMAN. Mr. Speaker, for a unanimous consent request, I yield to the gentleman from Iowa (Mr. BOSWELL).

(Mr. BOSWELL asked and was given permission to revise and extend his remarks.)

Mr. BOSWELL. I rise in support of this bill. The people in my area are waiting and so is my State and our country.

Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act.

Today, I am pleased to vote for the most transformative piece of legislation that I have considered during my 13 years in Congress.

I am voting to grant access to health care coverage for 18,000 uninsured constituents in my district and to make it more affordable for another 440,000 insured.

I am voting to guarantee that 6,400 of my constituents with preexisting conditions could never be denied coverage and to reduce insurance costs for 14,800 small businesses.

I am voting to finally address how Iowa's hospitals and providers are reimbursed for the care they provide.

Under this legislation, the Government will not force individuals and families with employer-based coverage to give up their insurance plans. However, as a result of the insurance reforms in this bill, they will no longer be required to pay co-pays or deductibles for preventive care; no more rate increases or coverage denials for preexisting conditions, gender, or occupation; and guaranteed oral, vision, and hearing benefits for children. The public option offered in the health insurance exchange would drive down costs across the board by fostering competition and expanding insurance choices.

Iowa's hospitals and providers have shouldered the burden of unfair Medicare reimbursements for the high-quality care they provide for too long. This bill will require studies on the reimbursement formula and move toward a payment system based on quality, not quantity. Providers who participate in the public option would be reimbursed through negotiated rates that balance what private insurance companies pay for services with the current Medicare rates.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. PERRIELLO) for the purpose of a colloquy.

Mr. PERRIELLO. Mr. Chairman, I recognize the good things this bill does to make health care more affordable for families and expand access to preventive and wellness care. I just want to clarify for the record that maternity care is a required benefit in the essential benefits package for all individual insurance and employer insurance across the country.

Mr. WAXMAN. If the gentleman will yield, yes, it is. That is a correct statement.

Mr. PERRIELLO. And it is my understanding that prenatal and postnatal care is generally considered to be part of maternity care, as recognized by organizations such as the American College of Obstetricians and Gynecologists.

Mr. WAXMAN. The gentleman is correct in that statement.

Mr. PERRIELLO. Thank you, Mr. Chairman, for this clarification.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Phoenix, Arizona, Congressman JOHN SHADEGG, a member of the committee.

Mr. SHADEGG. I thank the gentleman for yielding.

This is Maddie. Maddie believes in freedom. Maddie likes America because we have freedom here, and Maddie believes in patient-choice health care. She asked to come here today to say that she doesn't want the government to take over health care. She wants to be able to keep her plan.

You see, Maddie knows that if this bill passes, it says that her mom's health care goes away and won't be around in 5 years. As a matter of fact, the bill says, if the bill passes, then no more health care for her mom because it has to change.

Maddie wants patient choice. Maddie doesn't want her mom's premiums to go up. She doesn't want her mom's taxes to go up by $730 billion, do you, Maddie? That's too much money. She doesn't want a health care bill that will cost $1.5 trillion. She wants America's health insurance companies to have to compete with each other.

She believes in choice, but most of all, Maddie says, Don't tax me to pay for health care that you guys want. If you want health care, pay for it yourselves, because it's not fair to pass your health care bills on to me and my grandchildren.

Thank you, Maddie.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The gentleman is reminded not to refer to guests of the House as props.

Mr. WAXMAN. Mr. Speaker, that was a remarkable child and a great ventriloquist.

I would like to yield for a unanimous consent request to the gentleman from Virginia (Mr. BOUCHER).

(Mr. BOUCHER asked and was given permission to revise and extend his remarks.)

Mr. BOUCHER. Mr. Speaker, I rise in opposition to the bill.

Health care reform is needed. More than 36 million American citizens do not have health insurance, and millions more are underinsured and cannot afford to pay for the medical care they need. As those without insurance are treated in emergency rooms, the high cost of that care is borne by those who have insurance, driving up health insurance costs for everyone. The typical family pays an extra $1,100 each year in health insurance premiums as a cost of treating the uninsured. Health insurance premiums are increasing 3.5 times as fast as the rate of increase in family incomes.

This status quo is unsustainable, and finding a way for everyone to afford health insurance is necessary to benefit both the uninsured and those who have insurance. I hope that following a House-Senate conference on the legislation, we will be able to send to the White House the needed reform measure.

But reform legislation must ensure that Southwest Virginia residents continue to have access to the high quality health care services now delivered locally.

I oppose the health care reform legislation now before the House for several reasons including the continued existence of disparities in Medicare reimbursements between urban and rural areas under the House bill. Rural areas have traditionally received less under Medicare than urban areas, and while the bill makes some improvements in this regard, I would like to see more done to increase the payments to rural health care providers. Higher Medicare reimbursements would enable the attraction of more doctors to serve our medically underserved region.

I also oppose the bill because of my concern that a government operated health insurance plan could place at risk the survival of our region's hospitals. Most of our hospitals are operated on a non-profit basis for the benefit of the community. While most of their receipts are from Medicare and Medicaid payments, they lose money on each Medicare or Medicaid patient they treat. These programs reimburse hospitals at rates below the actual cost of providing patient care.

The financial viability of our hospitals comes from the payments they receive from privately insured patients. A government operated health insurance plan competing with private insurance will attract patients who are privately insured today, with the result that the hospitals would treat less privately insured patients and lose the critical revenues that are essential to their survival.

A government operated plan would reimburse health care providers at rates approximating Medicare rates, and hospitals would lose money on each of their patients insured under the government plan.

I am concerned that for these reasons the creation of a government operated insurance plan as envisioned in the House bill could result in the closure of hospitals in our region. Families depend on our community hospitals for health care services, and financially healthy hospitals are essential to the health of Southwest Virginians.

Many of our hospitals are financially stressed in normal times, and two hospitals in

the district I represent closed for periods of time in recent years for financial reasons. The government owned insurance plan as outlined in the House bill could push many more over the edge. I cannot support legislation that could lead to that result.

I also believe that bipartisan participation is needed on a measure of this scope which affects every American. The best ideas of Democrats and Republicans alike should be drawn upon to fashion the final legislation. That did not happen as the House bill was constructed.

In July, I opposed the health care reform measure when it was considered by the House Energy and Commerce Committee and expressed my concerns at that time. The bill passed by the House did not address those concerns.

Passage of the House bill is but a first step in a long legislative process to final enactment of a reform. I look forward to future steps in that process offering an opportunity for my concerns to be resolved.

Reform is needed, and I hope to support the final passage of legislation that emerges from a House-Senate conference that creates affordable access to health care for all Americans and does so in a way that enables the continued delivery of the excellent care now offered in our region.

Mr. WAXMAN. At this time, I yield 1 minute to the gentleman from the State of Maryland (Mr. SARBANES), a member of our committee.

Mr. SARBANES. Mr. Speaker, every day millions of people wake up with a knot in their stomach because they have anxiety and fear that they may lose their health care coverage or they don't have it to begin with. They need this health care bill. We in this Chamber are conscious of the sweep of history, but the people in my district and millions more across the country have a much less ambitious perspective. They just want to know is this a good bill, does it make sense, and will it help them and their families.

Well, if you are a senior, the answer is yes. We're going to begin closing the doughnut hole. If you are a young person, the answer is yes. You can now stay on your parents' policy through age 26. If you are a working adult, the answer is yes, because we're going to curb the abusive practices of the health insurance industry.

So what I want to say to people in my district and to others is this is a good bill, it makes sense, and it will help millions of Americans across this country.

I urge its passage.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the gentleman from the Hoosier State of Indiana, Mr. STEVE BUYER, another member of the Energy and Commerce Committee, and the ranking member on the Veterans' Affairs Committee.

Mr. BUYER. Mr. Speaker, in a few days, all of us are going to be going back to our districts. We are going to be celebrating Veterans Day. Many of you are going to be giving speeches. You are going to be throwing your arms around the soldier, the marine, the sailor, the airman, the coastguardsman. Do you throw your arm around them in this bill? You don't.

And when you go home and you give that speech, you can tap into the American character and you can say, Americans go to a land where they've never been to fight for a people that they've never met. They do so at no bounty of their own, and they leave freedom in their footsteps. Yet when they get to come home, how does our Congress right now treat them? In this 2,000-page bill, we deny them their rights of choice with regard to the health system which they can go to. Can you imagine that?

Now, I received a pledge not only from the Speaker, but also from the leadership, that veterans would be taken care of in this bill. My amendments were denied last night in the Rules Committee. How do you deny veterans their choice in this bill?

Shame on this institution.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would again remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the Rules of the House, and are asked to respect those rules.

□ 1545

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

Before I yield to another very important member of our committee, I just want to set the record straight. We keep faith with the veterans in this bill. We allow them to keep their veterans benefits. We allow them to keep their benefits. They may, if they choose to, go into the exchange; but if they don't, they keep their benefits.

Mr. BUYER. Will the gentleman yield?

Mr. WAXMAN. I yield 1 minute to the gentleman from Iowa (Mr. BRALEY), a member of the Energy and Commerce Committee.

Mr. BUYER. We do not. Mr. Speaker, we don't protect veterans' rights.

The SPEAKER pro tempore. The gentleman from California controls the time and has yielded to the gentleman from Iowa.

Mr. BUYER. * * *

The SPEAKER pro tempore. The gentleman does not have the time. The gentleman from Iowa has the floor.

Mr. BUYER. I ask that——

The SPEAKER pro tempore. The gentleman is asked to respect the rules of the House.

Mr. BUYER. I will.

Mr. BARTON of Texas. Mr. Speaker, I will yield 1 minute to the gentleman, if that's allowed.

The SPEAKER pro tempore. The gentleman from California has already yielded time to another Member.

Mr. BUYER. Just protect veterans and I'll go sit down.

The SPEAKER pro tempore. The Chair would ask that the gentleman abide by the rules of the House.

The gentleman from Iowa is recognized.

Mr. BRALEY of Iowa. I thank the chairman for his extraordinary leadership on this bill.

Mr. Speaker, I rise today on the third anniversary of my election to Congress to urge my colleagues to speak truth to fear and vote for the Affordable Choices for America Health Care Act.

We were elected, my class, to come and change the direction of this country. That's exactly what this bill does.

We just saw a beautiful young child. I want to tell you about another beautiful young child, Tucker Wright, my nephew's son, who at age 18 months was diagnosed with liver cancer, had two-thirds of his liver removed, and faces a lifetime of expensive medical care. Tucker was lucky because both of his parents work full time. Both of them have health care. And yet he still has tens of thousands of uninsured medical costs that his parents have to pay for.

That is what's wrong with health care delivery in this country. That's why we need to reform health care. And that's why this bill will do for America what we should have done 100 years ago: provide health care for all Americans as a matter of right, not as a matter of privilege. And that's why I support this bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished ranking member of the Financial Services Committee from the great State of Alabama, Mr. SPENCER BACHUS.

Mr. BACHUS. Mr. Speaker, when I joined the Army, they sent me to Fort Lewis, Washington; and one of the first things we did there was get in line to get our hair cut.

We noticed on the wall there were pictures of four different haircuts, and they told us to choose one of those haircuts, get a number, and give it to the barber.

We thought this was going to be pretty good. So we all gave him that number for the longest haircut. We all gave our numbers to the barber, and he cut all our hair off, every one of us. The numbers meant absolutely nothing.

When we got back to the barracks, we knew who was in charge. We knew who was making the decisions, and it wasn't us. The Army was making all the decisions.

Just like thinking you're going to get the haircut you choose, we're promised the right to choose under this bill. But the reality is, just like the Army, when the government's in

charge, you're not. This bill is about a new government bureaucracy making all the choices for us.

We're Americans. America is about freedom. Freedom is about making choices. And given the choice, I'll always put my faith in the individual, not the government.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from the State of California (Mrs. DAVIS) for the purposes of a colloquy.

Mrs. DAVIS of California. Mr. Speaker, I appreciate the opportunity to raise this issue also on behalf of my colleague from California, Congresswoman SPEIER.

Unfortunately, the provisions in section 309 allowing States to enter health insurance compacts may bring unintended consequences that could threaten long-established patient protections, and I know that that is not the intention.

I certainly plan on supporting this legislation today; but I would ask you for the commitment, Mr. Chairman, to continue working on the language in section 309 to ensure it does not impact strong State consumer safeguards such as we have in California.

Mr. WAXMAN. If the gentlewoman would yield, I thank you and I'm encouraged you and your staff have committed to further working on these provisions and not allowing health insurers to find loopholes in State laws.

Mrs. DAVIS of California. Thank you, Mr. Chairman. I look forward to that.

Mr. BARTON of Texas. Mr. Speaker, it is my privilege to yield 1 minute to Congressman FORTENBERRY of Lincoln, Nebraska, which today, since Oklahoma is playing Nebraska at Lincoln, is the largest city in Nebraska.

Mr. FORTENBERRY. I thank the gentleman for the insight.

Mr. Speaker, our health care system must be strengthened. No one disputes the diagnosis. We need to improve health care outcomes for all Americans and reduce costs, especially for small businesses and families, while we protect vulnerable persons.

But this bill is a massive, risky restructuring of our health care system. Why could there not be agreement on reasonable reforms such as portability of insurance, buying insurance across State lines, and creating new insurance association models for farmers and families, providing affordable options just like corporations have?

I agree we should promote a health care culture that focuses on wellness and prevention, removes lifetime caps, and expands high-risk pools to help those with preexisting conditions. However, I fear that this 2,000-page bill at $1.3 trillion will fail to reduce costs, would simply shift the costs to more government-run health care and reduce health care liberties.

Mr. Speaker, what is at issue now is winning and power, not effective, reasonable reforms. We've missed an opportunity. I cannot support this bill.

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Lubbock, Texas, a recent beneficiary of the best health care system in the world, Congressman RANDY NEUGEBAUER.

Mr. NEUGEBAUER. Mr. Speaker, I rise today as a proud cancer survivor.

August 1 of this year, I was diagnosed with the early stages of prostrate cancer. And thank goodness I live in America and I was able to sit down with my doctor and work out a treatment plan that would help me be cancer free and stand before you today. Thank goodness that I live in a country where I could go and see my doctor and make choices. And thank goodness I live in America where I didn't have to get on a list to determine when I was going to be able to have the surgery so that I could get rid of this cancer. Thank goodness I'm not living in Canada or Europe, the very system that our colleagues on the other side of the aisle are trying to model America's health care system on.

I thought about during August a young lady named Candy Menville that was crying in her wheelchair and begging me to make sure that we didn't turn our health care system in America into the same system that's in Canada and Europe. She said, Congressman, with tears running down her eyes, don't take away my options.

Mr. Speaker, don't take away Cindy's option and don't take away my options and others like me. Vote down this terrible bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SALAZAR). The Chair will remind all persons in the gallery that they are guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman is recognized for a parliamentary inquiry.

Mr. BARTON of Texas. We respect the ruling and the admonition about members of the gallery, but is it acceptable under the rules for the Members of Congress to show approval or disapproval of a speech on the floor?

The SPEAKER pro tempore. It is acceptable unless interrupting another in debate.

Mr. BARTON of Texas. Thank you, Mr. Speaker. We approve the Speaker's ruling.

Mr. Speaker, it is now my privilege to yield 1 minute to the gentleman from the State of Oklahoma (Mr. COLE), and it is with great pleasure that I announce that the entire Oklahoma and Nebraskan delegation who disagree on the outcome of the football game are all in agreement in opposing this bill.

Mr. COLE. I thank the gentleman for yielding.

Mr. Speaker, the Oklahomans I represent oppose this bill because they know what it does and what it does not do.

They know that this bill will raise taxes, not lower them. They know that this bill will grow government, not shrink it. They know that this bill weakens Medicare, not strengthens it. They know that this bill destroys jobs, that it doesn't create any. They know that this bill will force State governments to cut services and raise taxes, and it will put government bureaucrats rather than health care professionals in charge of their health care system.

Oklahomans know this bill does nothing to reform our tort system. They know it does nothing to give individual purchasers individual tax deductions. They know it does nothing to establish national insurance markets and association health plans that would allow small business to provide affordable insurance to their employees.

Oklahomans know the Pelosi health care bill is a giant step backward. And every Oklahoman in Congress will vote against this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. CUMMINGS).

Mr. CUMMINGS. Mr. Speaker, this afternoon we've heard a lot of people saying we should do what our constituents say that we should do.

I ask them what do I say to the gentleman in my district who is suffering from cancer and who is now trying to choose between eating and paying a high copayment for chemotherapy?

What am I to say to the young writer who for years paid her premiums and then, when she got pregnant and had her baby, they gave her a present on the way out the door that she could not afford: a $22,000 bill?

What do I say to a lady who suffered from breast cancer in my district and when she lost her job, lost her insurance, could not get insurance, could not get it because of something called preexisting conditions?

I would say to all those folks who are saying that we do not need this and must not do this, we have a moral authority to our fellow citizens. A moral authority.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to one of our pro-life leaders, the Honorable CHRIS SMITH of New Jersey.

Mr. SMITH of New Jersey. Mr. Speaker, today the House has an opportunity to significantly limit public funding of abortion in a manner that replicates the Hyde amendment and applies it to the two new massive government health care programs created in the pending bill: the public option and affordability credit program.

The Stupak-Pitts amendment ensures that pro-life Americans will not be forced to fund, enable, or facilitate the killing of unborn children and the wounding of their mothers.

Supermajorities, more than 67 percent, oppose public funding of abortion. Protecting vulnerable unborn children and women from the insidious violence of abortion is the human rights cause of our time.

So please let's not gloss over or trivialize the fact that abortion dismembers, decapitates, starves to death, or chemically poisons innocent babies, and that the abortion act itself, euphemistically called ''choice,'' can in no way be construed to be compassionate, benign, nurturing, or health care. Abortion is violence against women and children. It is neither health care nor reform.

Support the Stupak-Pitts amendment

Mr. WAXMAN. Mr. Speaker, I continue to reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. BARTON of Texas. Who has the right to close this part of the debate? Does Chairman WAXMAN have the right to close or does the ranking minority member have the right to close?

The SPEAKER pro tempore. There is only one overall right to close, and that will be the majority manager.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to Congressman JEB HENSARLING from the great State of Texas for 1 minute.

□ 1600

Mr. HENSARLING. Mr. Speaker, government-run health care is government-rationed health care. Today in America when our loved ones need health care, they wait hours, maybe days; but in Britain and Canada, they wait weeks, months, perhaps even a year.

Mr. Speaker, since I have been age 5, I have gone fishing with my father. Those are moments I treasure. But 15 years ago he went to see his doctor about a chest pain; 48 hours later, he had triple bypass surgery. And guess what? At age 81, we are still fishing. But had he been in Britain, had he been in Canada, there might never have been another fishing trip. My children might have never known their grandfather because health care delayed is health care denied.

Government-rationed health care will mean our loved ones will suffer. They will languish, and perhaps even perish. We should never support a children-bankrupting, health care-rationing, freedom-crushing $1 trillion government takeover of our health care system.

Let's support the Republican plan to give the American people the health care they need, when they need it, at a price they can afford.

Mr. BARTON of Texas. Mr. Speaker, I would like to recognize a Member from the great State of Georgia (Mr. KINGSTON) for 1 minute.

Mr. KINGSTON. Mr. Speaker, in January, with unemployment at 8.5 percent, Speaker PELOSI passed an $800 billion pork-ladened stimulus bill that was supposed to create jobs. In May, with unemployment up to 9.5 percent, Speaker PELOSI passed an energy tax of $1,500 on every household in America that was supposed to create green jobs. Now in November, unemployment is up to 10.5 percent, we have the highest deficit in the history of the country, a $12 trillion national debt, and Speaker PELOSI wants to spend $1 trillion on a government takeover of insurance.

This bill raises premiums. It raises taxes. It cuts Medicare, and it forces you to surrender your current health care coverage and puts a thousand bureaucrats in between you and your doctor.

The government couldn't even run Cash for Clunkers, and now it wants to take over 17 percent of the economy.

Let's vote ''no'' on the Pelosi plan and support the bipartisan alternative.

The SPEAKER pro tempore. The gentleman from Texas has 1½ minutes. The gentleman from California has 30 seconds.

Mr. BARTON of Texas. Mr. Speaker, I yield myself the balance of the Energy and Commerce time.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, first of all, let me tell you how proud I am of the members of the Energy and Commerce Committee on both sides of the aisle who have participated in this debate since January, and who have participated on the floor debate today. It makes me proud to be a member of that committee.

Mr. Speaker, we have heard all of the policy arguments pro and con for this bill. I am going to end the Republican side of the Energy and Commerce debate simply by saying that I think this bill should be defeated because it is an imposition on personal freedom here in America. I just simply don't think that it is right to tell people that they have to have insurance, tells employers they have to provide insurance, to set up a bureaucracy that advises a bureaucracy what that insurance should be, that then determines what the insurance itself should be, what the minimum premium should be, what has to be covered, what shouldn't be covered, and then over time almost guarantees that everybody, except the richest people in America, are in some version of the public option.

I just think that is wrong in America, Mr. Speaker, and for that reason alone I am against this bill.

There is an alternative. The Republican alternative covers many of the things that my friends on the majority side say they are for. We simply do it without mandating and imposing government will on the American people. Please vote ''no'' on the majority bill, and vote ''yes'' on the minority substitute.

Mr. WAXMAN. Mr. Speaker, 37 million Americans do not have health insurance because they can't afford it, their employers do not offer it to them, or they have a preexisting condition and the insurance companies deny it to them. We want them to buy the same policies that our Republican Members have talked about in such glowing terms, available to them and their families. Don't say ''no'' to 37 million Americans and tell them they have freedom. They don't have freedom to go without. In a country where people should not be forced into bankruptcy when they get sick, let's let people buy private insurance or a public option and get coverage.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) has 40 minutes and the gentleman from Michigan (Mr. CAMP) has 40 minutes.

The Chair recognizes the gentleman from New York.

Mr. RANGEL. Mr. Speaker, I would like to take this time to recognize the gentlewoman from Florida (Ms. WASSERMAN SCHULTZ) for 1 minute.

Ms. WASSERMAN SCHULTZ. Mr. Speaker, we have heard a lot of discussion in this debate about the uninsured and the uninsurable. Often it is easiest to think about people with preexisting conditions who are uninsurable as the poor, the sick, or the jobless.

Mr. Speaker, the face of the uninsurable stands before this House today in this well. As a breast cancer survivor, the sad reality of today's health care system is if I lost this job tomorrow, I could not buy health insurance coverage because I have a preexisting condition.

This bill will end all that. The Affordable Health Care for America Act will make it possible to rid our country of the angst of facing illness without coverage. Passage will mean that Carol from south Florida won't face the dual tragedy of a cancer diagnosis and the loss of her job and, thus, the loss of her health care coverage. So instead of putting all of her energy into fighting cancer, like I could, Carol had to fight for her health care coverage, too.

It is time to deliver on the American promise not just of liberty, but justice for all.

Mr. CAMP. Mr. Speaker, I yield myself 2 minutes.

Republicans have listened to the American people. It is clear from the Speaker's health care bill the Democrats have not. The Speaker crafted this bill behind closed doors and added 1,000 pages that have never been before a committee or had any input from the American people.

Just yesterday we confirmed that Americans could face 5 years in jail if they don't comply with the bill's demands to buy approved health insurance, and who knows what else we will discover over time. Simply put, the health care of the American people is too important and too complex to risk on this gigantic gamble. This bill will do lasting damage to our economy and

force millions of Americans to give up their current health care coverage.

With the national unemployment rate spiking to 10.2 percent, it should be unthinkable to pass this bill which contains more than $730 billion in taxes that will destroy millions more American jobs. The Democrats' bill cuts Medicare by one-half trillion dollars, slashing health care benefits for seniors, a direct violation of the President's pledge that Americans could keep what they have if they like it.

The Democrats' bill, when paired with an unpaid-for SGR fix, increases the deficit, a violation of the President's pledge that health care reform would not add one dime to the debt. The Democrats' bill drives up the cost of health care and increases Federal spending on health care by $600 billion, a violation of the President's pledge that health care reform would bend down the cost curve.

So you can't keep what you like if you like it. The bill spends over $1 trillion while raising taxes, cutting Medicare and increasing the deficit, and it drives up the cost of health care. The Democrat majority has not listened to the American people. Vote ''no'' on this bill.

Mr. RANGEL. Mr. Speaker, I would like to recognize the distinguished gentleman from Georgia (Mr. SCOTT) for 1 minute.

Mr. SCOTT of Georgia. Mr. Speaker, today the arc of history will hover over this House of Representatives, and the question facing each and every one of us today as 14,600 of our American citizens are losing their insurance every day is: where are we going to stand on this arc of history today? I ask you, are you going to stand with the negative forces of ''no'' or ''kill the bill'' or ''I object''? Or are we going to stand with the hope of America that has been expressed all of the way down from Teddy Roosevelt to Franklin Delano Roosevelt to Harry Truman to Lyndon Baines Johnson to Teddy Kennedy, and to JOHN DINGELL?

I say to you today, this House of Representatives, stand up and say I am not afraid of the future because the key to our future is to make sure that all Americans have access and have affordable health care insurance. That's what the American people are expecting us to do, to stand up for America.

Mr. CAMP. I yield to the gentleman from California for a unanimous consent request.

(Mr. ROHRABACHER asked and was given permission to revise and extend his remarks.)

Mr. ROHRABACHER. Mr. Speaker, I oppose this bill that will take hundreds of billions of dollars out of Medicare and give billions of dollars of health care to illegal immigrants.

Mr. Speaker, this attempt at sliding Americans into dependence on a government-controlled health care system brings bait and switch to a new low.

We have heard about the flaws of our current healthcare system, high costs, lack of portability, lose a job—lose health insurance, discrimination of those with preexisting conditions. Yes, many of the heart-wrenching stories we are hearing to justify this legislation are real. But correcting those maladies requires specific reform, not transforming healthcare in America into a bureaucratically-managed system that will cost hundreds of billions, including billions to provide healthcare for illegal aliens, while at the same time cutting Medicare by hundreds of billions of dollars. This so-called reform will destroy the freedom of the American people to make health decisions with a doctor of their choice. It will transform our system, rather than reform it. And what we will end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

You can touch our hearts with the stories of suffering brought about by defects in our current system, but it doesn't follow that we have to buy into this monstrous federal power grab. It is too benign to call this scheme bait and switch.

Wake up America!!

This bill cuts healthcare for our seniors by hundreds of billions of dollars while providing subsidized health care of illegal immigrants, which will draw more illegals into our country.

Wake up America!!

This bill is structured so that private companies will find it profitable to dump employees into the government-run option, rather than continuing to offer private health insurance.

Wake up America!!

This ill-conceived power grab will bankrupt our country as it destroys our freedom.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, a true American hero, the gentleman from Texas (Mr. SAM JOHNSON).

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, today we are voting on Speaker PELOSI's $1 trillion Washington takeover of health care. This bill bulldozes individual liberty and puts the government just where it doesn't belong, right smack dab in the middle of your personal health care decisions. This bill forces every single person in this country to purchase government-approved health care or go to jail. Businesses must also offer government-approved health care or face hundreds of billions of dollars in job-killing taxes.

Unfortunately, government-approved health care will be defined by a handful of bureaucrats around a conference table in Washington. This unprecedented Washington power grab eliminates an individual's right to choose what kind of health care is best for them and their families.

Speaker PELOSI's 20-pound, 2,000-page bill costs $2.2 million per word. The American public have made their voices heard. They are sick and tired of the government sticking its nose where it doesn't belong. They are fed up with Washington's trillion-dollar bailouts, free handouts and special interest paybacks.

The Democrats in Congress need to listen and come up with a bipartisan, patient-centered plan. We can do better with a targeted, fiscally responsible approach that makes health insurance more affordable, more accessible, and available. Real health reform protects a patient's right to choose their own care. Real health reform gives doctors the freedom to do what is best for their patients. We can do all of this without piling trillions of dollars of debt onto our children and grandchildren.

Vote down this deficit-ballooning, job-killing, Washington takeover of health care today.

Mr. RANGEL. Mr. Speaker, I would like to recognize my friend and colleague, the outspoken Member from New York, Mr. NADLER, for 1 minute.

(Mr. NADLER of New York asked and was given permission to revise and extend his remarks.)

Mr. NADLER of New York. Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and for universal health coverage. This historic bill goes a long way toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage. Families go to sleep at night knowing that they are one serious illness away from bankruptcy. And the unemployed are people who face going it alone in the prohibitively expensive individual coverage market or, worse, going without insurance at all.

□ 1615

While I would have preferred a single-payer system, I am happy to support a bill that contains a public health insurance option that will provide competition to the private insurance companies and will drive down rates.

This bill will end discrimination against people with preexisting health conditions, will end the practice of dropping patients when they are sick, and will strengthen and enhance Medicare by ending the doughnut hole and extending the solvency of the Medicare Trust Fund.

Mr. Speaker, the status quo is not an option. We have an opportunity to get universal health care coverage in this country to implement the competitive public health insurance option that puts the patient before the quarterly financial report, and to ensure that just because you lose your job, you won't lose your health insurance.

This is monumental and historic, and I am proud to support the Affordable Health Care for America Act.

Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and universal health coverage. This historic bill, H.R. 3962, makes great strides toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage, with another 14,000 Americans joining the ranks of the uninsured each day. We see families who go to sleep at night knowing they are one serious illness away from bankruptcy, the reason

for 55 percent of all bankruptcies filed last year. We see the rising ranks of the unmployed who face going it alone in the prohibitively expensive individual coverage market—or worse, going without insurance at all. And we see 20,000 people die every year because they have no health insurance.

At the same time that this stark reality hits hardworking Americans, insurance companies have conspired to keep costs high. These costs, upward of 15–35 percent squandered on outrageously high administrative costs, do nothing to make people healthier but do much to line the pockets of insurance companies and help their corporate bottom line.

This is unacceptable. We must take action. That's why I support the Affordable Health Care for America Act.

As with any legislation, there have been some compromises made along the way. I would have preferred a single payer system, the most effective and least costly way to implement a health delivery system. But I, like so many of my colleagues, have come to see a competitive public option as the best available way to refocus our misguided health care approach. A public option will put patients and doctors, not corporate bottom lines, at the forefront. This public option will add much needed competition into an insurance market that must be kept honest, and it will work to drive down rates.

Mr. Speaker, this past August, political pundits and TV-talking heads had the public option dead on arrival. Yet, because of the efforts of progressive Members in Congress, in which I was proud to join, we succeeded in keeping the public option in this bill and ensured that the American people would be given an alternative to corporate health insurance. And make no mistake about it—the public option weathered the storms of misinformation, slander, and downright lies because the American people saw through the political game playing and saw the public option for what it is—an option, not a mandate, that will help stem the cost of ever-rising health care costs.

In addition to the public option, this national health reform bill implements key insurance industry reforms, strengthens Medicare, and immediately gives hope to the millions of Americans currently living without health insurance.

It will end discrimination against pre-existing conditions, and end the cruel practice of rescission, which allows insurance companies to drop people from coverage if their illness is considered too expensive. This bill also guarantees that people with insurance will not face devastating costs when they get sick by placing limits on out-of-pocket medical expenses, and creating, for the first time ever, a voluntary long-term care program. And H.R. 3962 would end the blanket exemption insurance companies currently enjoy from anti-trust laws. With this change, we can now bring anti-trust enforcement against the egregious practices of price-fixing and market allocation.

H.R. 3962 contains numerous provisions that help our seniors by strengthening and enhancing the Medicare program. This bill reduces the donut hole to $500 immediately and eliminates it entirely by 2019. It allows the HHS secretary to negotiate prescription drug costs, which I have long advocated for, eliminates out-of-pocket expenses for preventive care for seniors, and extends the solvency of the Medicare trust fund for at least five years.

Small businesses also receive desperately needed assistance from this bill. Initially, businesses with up to 25 employees, then growing to businesses with up to 100 employees by 2015, will be able to join the health exchange, which will allow small business employees to take advantage of group rates and a broader range of insurance options—a key change that will go a long way toward helping small businesses keep down their number one expense, which is the cost of providing health care coverage.

For America's young people, who make up 29 percent of the uninsured in America, H.R. 3962 will permit parents to extend coverage to their children until their 27th birthday.

To help American families defray the costs of health coverage, this bill extends assistance on a sliding scale to families earning up to $88,000 per year. This will go a long way toward ending the cruel choice between health care coverage and other necessities.

Mr. Speaker, there are some who have said that health care reform is too hard. There are those who have allowed misinformation and politics to push them to root against helping their fellow Americans to have access to quality, affordable health care. There are even those who, for reasons I fail to grasp, want to continue with the status quo.

To those people, Mr. Speaker, I say—the status quo is not an option. We have a remarkable opportunity in front of us. We have an opportunity to make fundamental changes to the way we view health care and deliver services, to implement a competitive public health insurance option that puts the patient before the quarterly financial report. And, with passage of this bill, we will be able to say for the first time in this country that just because you lose your job, you won't lose your health insurance.

Mr. Speaker, this is monumental. This is historic. And I am proud to cast my vote in favor of the Affordable Health Care for America Act.

Mr. CAMP. At this time, I yield 2 minutes to the distinguished gentleman from the Ways and Means Committee, the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, this is the Pelosi health care plan, and it's wrong for America. Over 100 new Federal agencies, commissions, and mandates standing between you and your doctor.

This huge, inefficient new bureaucracy makes your health care insurance more expensive, forces millions of Americans into a government-run plan, raises taxes on workers and small businesses, increases Medicare drug costs for seniors, adds billions to our frightening deficit, and after throwing $1 trillion at the problem, still leaves 18 million Americans uninsured. Big government doesn't mean better health care.

To pay for this massive new bureaucracy, Democrats slash Medicare for our elderly by a half-trillion dollars. That means 660,000 Texas seniors are going to lose their plan. It shuts 40 doctor-owned hospitals in Texas, costing us 15,000 jobs. And 1.5 million Texans will have their plans disappear.

This is not the reform families need. Instead, this is all about taking the giant first step toward a single-payer national health care system. If the Pelosi plan passes, Washington will ultimately decide which doctors you can see, what treatments you deserve, and what medicines you receive, and when you're sick, will you be worth their cost?

House Republicans have a different vision. We listened. Ours is a careful, step-by-step solution to the complex issue of health care, focusing first on lowering your health care costs so more can afford it. We have no tax increases, no Medicare cuts, no rationing, no mandates, no huge intrusion of government into the most intimate parts of your health care, just more choices, more fairness, less lawyers. Best of all, our Republican plan is the only reform that actually lowers your health care premiums and lowers the deficit.

We need to get health care reform right the first time. The Pelosi plan is wrong.

Mr. RANGEL. Mr. Speaker, for another view of health care in Texas, I yield 1 minute to Ms. JACKSON-LEE.

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, today I am holding up a concise, efficient, and effective health care plan for America, H.R. 3962, and I plan to stand with America and those who don't have health insurance today as we cast our vote for affordable health care for America.

Eighteen thousand people die every year because they do not have health insurance. The State of Texas has 6 million people who don't have health insurance. Several Republican Members from Texas, have in their districts, some 29 percent, and 18 percent of individuals who don't have health insurance.

So today I rise to say that the plan we have will immediately close the doughnut hole for Seniors. It will provide the uninsured with a bridge to the exchange program. It will extend the coverage for our young people until the age of 27, and, yes, I'm proud of the language on pages 22 and 23 that will begin to help save hospital beds in physician-owned hospitals in the State of Texas and around the Nation. This language is in the bill and we now can continue to work competent quality hospitals in rural and urban areas.

We are ready to fight. We are ready to make sure that those who need health insurance will have us on their side. I am standing with America and voting for America for the first time in which a health care reform bill passes the House with a Public Option to give more access to Americans and lowers the costs of health care insurance. Vote for the health care bill now.

I rise before you today in support of H.R. 3962, the Affordable Health Care for America Act. On July 5, 1965, President Lyndon Johnson said the following about the passage of Medicare, "This bill is sweeping in its intent

and impact. It will help pay for care in hospitals. If hospitalization is unnecessary, it will help pay for care in nursing homes or in the home. And wherever illness is treated—in home or hospital—it will also help all Americans.'' My friends we can all say that about this sweeping legislation. Madame Speaker, while some say that patients and physicians oppose this bill I know otherwise. Today, I met with dozens including physicians, medical students, patients, and advocates. This group included representatives from Doctors for America, National Physicians Alliance, American Medical Student Association, US PIRG, Disciples of Christ, Episcopal Church, NETWORK—A Catholic Social Justice Lobby, United Church of Christ, and United Methodist Church along with a nationally renowned cardiac surgeon Dr. Salim Aziz of the George Washington University Medical Center.

The health providers with whom I met are on the front lines of the health care debate every day. As such, it is no surprise that they enthusiastically endorse this bill, while holding out hope for progressive changes to health reform legislation before it becomes law. These health professionals see the pain and frustration of hardworking Americans who face financial collapse, physical suffering, and sometimes the loss of their life simply because they do not have decent health care coverage.

Allow me to share with you some of the stories that I've heard from these care givers. One story was that of Dr. ''Alex'', a Pediatrician and Health and Evidence Policy Fellow at Mt. Sinai School of Medicine. Dr. Alex told me of an illness he suffered himself while still a medical student at Howard University College of Medicine here in Washington, DC. One summer, during an internship at the Centers for Disease Control in Atlanta, Dr. Alex became very sick, and was examined at an emergency room. The examination revealed that Dr. Alex's ailment arose from acute kidney failure.

Dr. Alex thankfully had health coverage through Howard University's student health insurance plan. Yet he was faced a conundrum since the university's plan only covered health services required by their students in Washington, DC. It didn't cover him in Atlanta, thus Dr. Alex qualified as under-insured. Aware that he could not afford out-of-pocket payment for a renal dialysis unit as was being recommended, by his physician, his father drove him through the night from Atlanta, waking him every few minutes to make sure he was responsive, until they finally reached Washington, DC, the next morning, where he could get the treatment needed. This story is proof of the fact that even those who chose to enter the profession of caring for others are not immune to the dysfunction of our health care system. Dr. Alex also related another interesting paradox that I'll share with you. He trained in pediatric medicine at a county hospital outside of Los Angeles. At this county hospital I cared for uninsured children, and those enrolled in SCHIP and Medicaid. What he most enjoyed about working within that system was that they provided high quality care to those who needed it the most. His patients on Medicaid and SCHIP were able to easily see sub specialists: Dermatologist, Ophthalmologist, and Gastro-intestinal physicians. His patients who had private insurance often faced health care barriers which his patients on SCHIP and Medicaid never had to navigate. When children who had private medical insurance visited his county hospital pediatric clinic, staff there had to seek preapproval from the private insurance company so that patients' parents were not billed and required to pay the cost of care out-of-pocket. In this county pediatric clinic he once cared for a 9-month-old boy who had a swollen face covered in a rash on his forehead and cheeks, and raw in his neck folds. He sat before him and scratched his arms, trunk, and face uncontrollably to the point of bleeding. Because of his constant scratching his skin had started to harden. He had uncontrolled eczema and his mother told him in tears how she had not been able to obtain a referral to a dermatologist. The county pediatric dermatologist's one afternoon a month clinic time was that same day. To prevent the patient's mother from receiving a large medical bill, Dr. Alex did what he normally did; he got on the phone to her private insurance company and asked the insurance bureaucrat to agree to pay for the visit. As his other patients had to wait for him, he wasted time on the phone trying to solicit preapproval from her insurance company. But he could not sway the insurance gatekeeper. He tried his hardest to make this bureaucrat understand the child's bloody scabs, the mother's tears. But to no avail. The dermatologist took pity on the child and did what we physicians often do, he saw the patient for free.

Why have we allowed insurance bureaucrats to come between Dr. Alex and his patients? We can do better than allow profit driven bureaucrats decide what medicines my patients receive. He wants a health care system where when he writes a prescription his patient does not have to worry whether their insurance company will pay for it. An insurance bureaucrat sitting in their cubicle should play no part in the relationship between me and my patient. We need to reform our system.

Today is a historic day not only for the 39 million uninsured Americans, but also for our great Nation. As Speaker PELOSI remarked earlier today, we, Members of Congress, are ''humbled to stand here at a time when we can associate ourselves with the work of those who passed Social Security, those who passed Medicare, and now we will pass health care reform.'' Many parallels exist between that history and today. Today, we listened to a parade of Republicans warn that this bill will bring the downfall of American society, of the American way of life. This is not the first time that the Republicans have been on the wrong side of history. In an interview in 1975, David L. Kopelman, who played a prominent role in the early administration of the Medicare Program, remarked that his colleagues were often criticized by Republicans. ''Communist,'' he recalled, ''was the designation all too liberally applied to anyone with a progressive idea. Well, after all, when we went around making contact with employers in those early years that was the designation not delicately applied by many, if not most of them, to the social security program. It must be some communist scheme foisted on the American people.'' Alf Landon, the Republican candidate for President in 1936, even campaigned on the fact that not a dollar in social security benefits would ever be paid.

Mr. Speaker, unfortunately, such ad hominem attacks are as prevalent as ever. The Republicans want you to believe that our country is descending into an abyss of socialism, but nothing could be further from the truth. Today, I am proud to support a bill that is distinctly American. We the people, Thomas Jefferson wrote in the Declaration of Independence are endowed ''with certain unalienable Rights that among these are Life, Liberty and the pursuit of Happiness.—That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed . . .'' I believe that it is no coincidence that life is listed first—for without it, the Founders realized, no other rights can be realized. Over years, the millions of Americans who could not access medical services were denied their most basic right. The value of life is echoed in the Universal Declaration of Human Rights as well as in the Hippocratic Oath taken by every physician.

True, health insurance is not a human right by itself, but consider the following: according to the National Academy of Sciences, Institute of Medicine, there is a ''consistent and statistically significant relationship between health insurance coverage and health outcomes for adults. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and the treatment of acute conditions . . .'' This year, a study published in the American Journal of Public Health by researchers at Harvard University Medical School concluded that nearly 45,000 excess deaths of Americans can be linked each year to lack of health insurance. Forty-five thousand is fifteen times the death toll at the World Trade Center; 45,000 people are approximately equal to the population of Texas A&M University; 45,000 is almost thirty times the number of American soldiers killed in Iraq since 2001. The lives lost at the World Trade Center and in Iraq will never be forgotten. Why then, do we pretend that a far greater loss of life every year does not exist? Make no mistake about it, health insurance can be a direct determinant of whether somebody lives or dies.

According to the U.S. Census Bureau, 27 million American live without health insurance, and an additional 1.1 million part-time workers lost their health insurance in 2008. Implementing this legislation will instantly improve the life expectancy of millions of Americans of all ages. It is impossible to put a price on that. When we talk about the right to healthcare, we are actually talking about the right to access healthcare. In our current system people do not choose to be uninsured but, instead, are priced out of insurance. These people cannot, as free market proponents often argue, ''Pull themselves up by their bootstraps.'' Instead, they and their families are too often cyclically and systemically trapped in their economic situation. Texas, in particular, with 6 million uninsured persons and 26 percent in the 18th Congressional—H.R. 3962 must pass.

I am committed to working with the Speaker's office and Senatorial leadership now that we are taking the first step in stemming the rising tide of the many uninsured. The protection of physician-owned hospitals is an issue of national interest. We have a lot of work to do as we move toward the Senate and to the conference. I was gratified to meet with the Speaker today to discuss the continued protection of the very viable physician-owned hospitals.

I will continue to work to save physician-owned hospitals that are currently treating patients or under significant development, to ensure that Americans can continue to receive healthcare at the local hospitals they have come to depend upon. Physician-owned hospitals take care of patients covered by Medicare and Medicaid, as well as patients who are uninsured or cannot pay for their care. They also provide emergency departments access for their communities. At a time when we are concerned about the shortage of hospital beds in the face of epidemics like the swine flu, my amendment to this landmark bill will make sure no hospital is forced to shut its doors or turn away Medicare or Medicaid patients. The benefits that will come from our efforts to protect physician owned hospitals are far reaching and will prevent any further losses to local economies. Not only do physician hospitals deliver high quality medical care to the patients they serve, they also provide much needed jobs, pay taxes, and generate significant economic activity for local businesses and communities. Existing physician-owned hospitals employ approximately 51,700 individuals, have over 27,000 physicians on staff, pay approximately $2,421,579,312 in payroll taxes and $512,889,516 in other federal taxes, and have approximately $1.9 billion in trade payables. Hospitals currently under development would employ approximately 21,700 more individuals. With approximately 50 physician-owned hospitals, Texas leads the nation in the number of physician-owned hospitals. The Texas economy could lose more than $2.3 billion and more than 22,000 jobs.

In my district, the 18th Congressional District of Houston, Texas, St. Joseph Medical Center is a general acute care hospital that treats all patients. In fact, its 40 percent Medicaid patient population is double the average hospital's patient population in the entire State of Texas and is one of the highest in the country. St. Joseph's was operated by the Sisters of Charity for many years until it was scheduled to be closed because the order could no longer support it. The hospital was offered to for-profit and not-for-profit hospital systems but no one would accept responsibility for operating St. Joseph's. A plan was developed to convert the hospital into condominiums. I refused to allow that to happen. It was only at that point that the physicians who had practiced there for many years came together to buy the hospital to save it from closing.

St. Joseph's takes care of patients covered by Medicare and Medicaid, as well as patients who are uninsured or cannot pay for their care. The emergency departments of many physician-owned ''specialty hospitals'' have been criticized for not having a true emergency department. St. Joseph's has a department which is open 24 hours per day, 7 days per week, providing an access point for patients in need of emergency services. In fact, St. Joseph's admissions through the emergency department are double the State average;

St. Luke's hospital in Houston, which is church-owned, has three new facilities under development; the nonprofit religious mission has the controlling interest. One full-service hospital has one phase already operating, but would be under the growth restrictions; the hospital cannot be completed if the new restrictions apply. The hospital brought approximately 300 new jobs to the community; and

Baylor Health Care System, based in Dallas, has found that their partnership with physicians has increased measurable quality, increased patient satisfaction, and decreased the cost in the delivery of their excellent care. This joint venture model has produced a heart hospital that has the lowest readmission rate in the entire United States. And yet this bill would deny Baylor Health Care System the right to add a single operating room or procedure room to meet its community's need. During the moratorium on physician-owned hospitals some years ago, Baylor wanted to add a badly needed OB/GYN service at its Frisco, Texas, hospital. This service is a money losing service, but there was no such service within many miles for those people—Baylor fulfilled the need. It was prohibited from adding this service simply because the hospital had physicians holding a minority of the ownership of the hospital. After the moratorium was lifted, the service was added and is currently working at its capacity.

Mr. Speaker, can we imagine witnessing an impact, of no patient beds, 6- to 8-hour waiting times, to extend even to 10-hour waiting times, turning emergency patients away at the door? Can we imagine the dramatic case, when patients are not able to have access to quality care? This is true of the most serious trauma, of the most serious medical cases. Physician owned hospitals serve in many cases at least 40 percent of the city's population. I don't just mean the city's population. We are discussing a population that is between 500,000, which is the indigenous population, and the population of 1.5 million that's in the city every day.

When a hospital downsizes in a particular city, it extends beyond the boundaries of that city, and in doing so, with this hospital being downsized, it's impacting all of the hospitals, not only in the city, but those hospitals in nearby jurisdictions. We're seeing the epicenter of a catastrophic event, and unless we realize the importance of this one medical facility, but look at it not from the perspective that it serves this city, but we have to realize that it serves the world. It serves the Nation. At the very least, it serves the Nation; at the very most, it most serves the world. So when you start looking at it from those perspectives, then it becomes more than just a problem of Houston, Texas, but a problem of this Nation. And it should be addressed in that manner.

If we do not work closely together to look deeper at this issue, we will face a number of medical facility closures that is a disservice to the American people. So, we see that there seems to be a phasing-back or cutback in all of the major services, but the most important of those services, which directly affect the health and well-being of the citizens, or again, those 1.5 million people who visit and work in the city every day. So, we hear the same thing time and time again, even though individuals are saying that the patient caseload can be handled by the surrounding hospitals. You need but step into any emergency room on any day, at any time, and just see the impact of this one hospital being downsized. The impact will reach out throughout the city of Houston.

Again, a true indication of the success of any city government, or any country, is its ability to care for its weak, its injured, its sick, its young, and its old. The ability to care—compassion. Let us be honest—we see the faces of those individuals who we cannot help, because the system has failed them, and they ask us for help. What do we tell them? You never want to lie to a patient. You want to be honest and up-front with this patient. But you reach a point where, in some cases, it's best that you say nothing.

How can we tell a family member sitting across from me, in the back of my ambulance, with their loved one lying on the cot as we do CPR, cardiopulmonary resuscitation, on them, ''Ma'am, I'm sorry, we're going to have to go on the other side of the city because St. Joseph's Hospital is closed''? Then, when we get there, the doctors come to the family member and say, ''I'm sorry, your husband, your son, your daughter, your child, has died.''

How do we explain that to them: We passed the hospital that may have made the difference in this case. The ability to care, to show compassion: It's just apparent to me that that just doesn't exist now. To sign off on anything less is to simply say, we turn our back on the community; we turn our back on the Nation. To do that, is to give away what makes us human. I think now is the time that we make that decision: Whether we are unwilling to turn away from what makes us human, or give in to those individuals who seek to benefit from others' miseries. Those individuals know who they are. I think now is the calling time. Now the horn is being blown, and we've got to answer. But first, the failure of every part of civilization is first, the inability to care for its population. From there, it tends to go downhill.

This is a national problem, but we should be setting the trend, we should set the example for the entire Nation that hospitals like St. Joseph's Hospital do more than just care for our sick and injured. They represent our capacity to care. There is a duty to act and a passion to care.

H.R. 3962 is a bill that will change the health dynamics positively for all Americans—but it is a work in progress. In the manager's amendment after weeks of meeting with the leadership our efforts to seek some relief for physician-owned hospitals was achieved. It is not a winning formula, however on pages 22–23 of the manager's amendment we secured language that says that all physician-owned hospitals should not be treated alike. I have introduced two amendments to cover extending the grandfathering in of physician-owned hospitals and on criteria for other physician-owned hospitals. However, our work is not finished—we must work with the Senate and in conference to keep quality health care.

For the RECORD, I have attached a chart on Texas uninsured, benefits for the 18th Congressional District, and physician-owned hospitals.

This is a vital issue which must be corrected or the bill moves through Congress and for physician-owned hospitals to survive and grow. Martin Luther King, Jr. often told the story of the priest, the Levite and the good Samaritan. ''The first question that the priest and Levite asked was ''If I stop to help this man, what will happen to me?'' But, the Good Samaritan reversed the question ''If I do not stop to help this man, what will happen to him?'' Today, we can be the Good Samaritan—to help all Americans access good health care. Finally a special thanks to Chairmen RANGEL, WAXMAN, and MILLER and a very, very thank you to Congressman JOHN DINGELL and the late Senator Edward M. Kennedy.

No insurance. Texas has the highest rate of uninsured with about 6 million uninsured.

Texas Districts with the highest percentage of uninsured constituents. Rank shows district ranking out of 435 nationally.

Rank, Representative, district No., and percent uninsured:

1. Ruben Hinojosa, District 15—46.4 percent.

5. Gene Green, District 29—36.4 percent.

6. Henry Cuellar, District 28—34.1 percent.

8. Silvestre Reyes, District 16—33.3 percent.

12. Eddie Bernice Johnson, District 30—32.3 percent.

19. Sheila Jackson Lee, District 18—29.7 percent.

22. Solomon Ortiz, District 27—28.6 percent.

23. Louie Gohmart, District 1—26.9 percent.

24. Jeb Hensarling, District 5—26.8 percent.

27. Ciro Rodriguez, District 23—26.4 percent.

Other South Texas Districts:

37. Lloyd Dogget, District 25—25.0 percent.

40. Charlie Gonzalez, District 20—24.7 percent.

48. Ron Paul, District 14—23.7 percent.

124. Lamar Smith, District 21—18.3 percent.

BENEFITS OF THE AFFORDABLE HEALTH CARE FOR AMERICA ACT IN THE 18TH CONGRESSIONAL DISTRICT OF TEXAS

The Affordable Health Care for America Act will make health care affordable for the middle class, provide security for seniors, and guarantee access to health insurance coverage for the uninsured—while responsibly reducing the federal deficit over the next decade and beyond. This analysis examines the benefits of the legislation in the 18th Congressional District of Texas. Congresswoman Sheila Jackson-Lee represents the district.

In Congresswoman Jackson-Lee's district, the Affordable Health Care for America Act will:

Improve employer-based coverage for 279,000 residents.

Provide credits to help pay for coverage for up to 186,000 households.

Improve Medicare for 70,000 beneficiaries, including closing the prescription drug donut hole for 5,300 seniors.

Allow 16,600 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 14,600 small businesses.

Provide coverage for 187,000 uninsured residents.

Protect up to 500 families from bankruptcy due to unaffordable health care costs.

Reduce the cost of uncompensated care for hospitals and health care providers by $49 million.

AFFORDABLE AND IMPROVED HEALTH CARE COVERAGE FOR THE MIDDLE CLASS

Better health care coverage for the insured. Approximately 41% of the district's population, 279,000 residents, receive health care coverage from their employer. Under the legislation, individuals and families with employer-based coverage can keep the health insurance coverage they have now, and it will get better. As a result of the insurance reforms in the bill, there will be no co-pays or deductibles for preventive care; no more rate increases or coverage denials for pre-existing conditions, gender, or occupation; and guaranteed oral, vision, and hearing benefits for children.

Affordable health care for the uninsured. Those who do not receive health care coverage through their employer will be able to purchase coverage at group rates through a health insurance exchange. Individuals and families with an income of up to four times the federal poverty level—an income of up to $88,000 for a family of four—will receive affordability credits to help cover the cost of coverage. There are 186,000 households in the district that could qualify for these affordability credits if they need to purchase their own coverage.

Coverage for individuals with pre-existing conditions. There are 27,600 individuals in the district who have pre-existing medical conditions that could prevent them from buying insurance. Under the bill's insurance reforms, they will now be able to purchase affordable coverage.

Health care and financial security. There were 500 health care-related bankruptcies in the district in 2008, caused primarily by the health care costs not covered by insurance. The bill caps annual out-of- * * *.

Mr. CAMP. Mr. Speaker, at this time, I yield 2 minutes to the distinguished ranking member of the Budget Committee and distinguished member of the Ways and Means Committee, the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Speaker, I would like to place in the RECORD a statement commending the people at CBO for their long hours and hard work.

Mr. Speaker, I firmly believe that this is probably the most consequential vote each of us will take in our service here, whether you've been here for 40 years or for 1 year.

When you expose this bill's budget gimmicks, does it increase the debt and deficit? Yes. Will it take coverage away from seniors, raise premiums for families, and decrease health care innovation? Yes. Will it raise taxes on small businesses and workers and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes. Does this bill mean the government will take over running our health care system? Yes.

But what is worse is this bill replaces the American idea with a European-style social welfare state. This bill, more than any other decision we are going to make in this body, will do more to put millions of Americans as dependents of a state rather than being dependent upon themselves.

This is not about health care policy. If it were, we could pass a bipartisan bill to fix what's broken in health care without breaking what's working in health care. This is about ideology.

My friends, the choice is not whether you're going to stick with your party leaders. The choice here is what side of history do you want to be on? Will you be on the side of history where you stick with the people and the principles that built this exceptional Nation? That is the choice we are going to make with this bill, and I encourage you to think it through.

It is unusual for the House to be in session working on a Saturday. That has not been the case for the Congressional Budget Office's staff that has been working on health care legislation. For the past several months, CBO has worked non-stop to analyze health care legislation. This legislation is enormously complex and far-reaching and CBO is doing their best to fulfill their mission to provide objective non-partisan analysis to the Congress. That analysis is critically important to us and I want to acknowledge the hard work of Director Doug Elmendorf and the following CBO staff in that endeavor:

Alexandra Minicozzi, Allison Percy, Andrea Noda, Anna Cook, April Grady, Athiphat Muthitacharoen, Ben Page, Bruce Vavrichek, Assistant Director for Health and Human Resources.

Carla Tighe Murray, Chapin White, Christi Hawley Anthony, Colin Baker, Daniel Kao, David Auerbach, David Austin, David Weiner, Doug Elmendorf, Director.

Elizabeth Bass, Ellen Werble, Heidi Golding, Holly Harvey, Deputy Assistant Director for Budget Analysis, Jamease Kowalczyk, James Baumgardner, Deputy Assistant Director for Health, Janet Holtzblatt, Jean Hearne.

Jodi Capps, Joyce Manchester, Unit Chief, Long Term Modeling Group, Julia Christensen, Julie Lee, Julie Somers, Julie Topoleski, Kate Massey, Unit Chief, Low-Income Health Programs and Prescription Drugs Cost Estimates.

Keisuke Nakagawa, Kirstin Nelson, Kurt Seibert, Lara Robillard, Leo Lex, Unit Chief, State and Local Government Cost Estimates, Lisa Ramirez-Branum, Lori Housman, Lyle Nelson, Matt Schmit, Matthew Goldberg, Assistant Director for National Security.

Mike Carpenter, Mindy Cohen, Noah Meyerson, Noelia Duchovny, Patrick Bernhardt, Paul Burnham, Paul Jacobs, Pete Fontaine, Assistant Director for Budget Analysis.

Phil Ellis, Unit Chief, Health Policy Analysis, Rebecca Yip, Robert Stewart, Sarah Jennings, Sean Dunbar, Sheila Campbell, Stephanie Cameron, Stuart Hagen, Sunita D'Monte, Susan Labovich, Tom Bradley, Unit Chief, Health Systems and Medicare Cost Estimates.

Mr. RANGEL. Mr. Speaker, I couldn't agree with the last speaker more. This is an historic moment, and I certainly hope you, your friends, and colleagues think this through for the American people.

At this time, I have the pleasure to present to the body Mr. Lacy Clay, the gentleman from Missouri, and yield him 1 minute.

Mr. CLAY. I thank the distinguished chairman for yielding.

Mr. Speaker, I rise today to support a monumental piece of legislation that will expand health care coverage and reduce cost.

Currently, 46 million Americans are uninsured, and by 2019 the number could reach over 65 million. Too many are denied access to care, often when they need it most. No one should be denied coverage because of a preexisting condition, and no one should have to fear losing their coverage after they get sick. Even individuals who have health insurance suffer. Millions of underinsured Americans pay exorbitant fees for procedures and treatments that their insurance plan should cover.

The status quo is not working for Americans. It is time to take action. Each Member in this body should ask themselves one question before they vote, and that is: Am I my brother's keeper? And my answer is: Yes, I am.

Mr. CAMP. I yield 2 minutes, Mr. Speaker, to the distinguished member of the Ways and Means, the gentleman from California (Mr. HERGER).

Mr. HERGER. Mr. Speaker, today I rise not only on behalf of my constituents in northern California, but on behalf of all Americans. They have made

their opposition to government-run health care known. They have come out by the thousands to town halls, called our offices, and held peaceful rallies, but, unfortunately, congressional Democrats have refused to listen.

The legislation being considered today is one of the most damaging, destructive bills ever to come before this Chamber. A government takeover of health care won't bring down cost, but it will bring down quality of care. It will explode the national debt at the expense of future generations. It raises taxes by $750 billion and guarantees middle class tax increases down the road.

We all agree that we need health care reform, but we don't need to put the government in charge. Mr. Speaker, I believe in the free market, I believe in choice and competition, and I believe in freedom to choose your doctor and to get the treatments you need. America was built on these principles, and the Pelosi health care plan will take us in the opposite direction.

I urge every Member of the House to live up to our obligation, listen to the people and say ''no'' to government-run health care.

Mr. RANGEL. I yield myself 30 seconds, Mr. Speaker, because the gentleman who just spoke said that the Democrats didn't listen to the Republicans. Having had the honor to serve with outstanding Republicans on the Ways and Means Committee and having, as chairman, had hearings last year and throughout, quite frankly, there wasn't much to listen to until last Tuesday when, for the first time, you presented a bill. In any event, I appreciate the gentleman's contribution.

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

Mr. RANGEL. I yield myself such time as I may consume.

We have been designated as one of the three committees to work on this bill for the President and for the House of Representatives. And we were privileged to work with Chairman WAXMAN as well as Chairman MILLER. I don't think in the history of the Congress we have found three separate committees working in such cooperation. But as I said earlier, we had such hardworking, dedicated members and such a strong support staff that it's almost embarrassing that they are so limited in sharing with you the work and the time and support that they've given to this important issue for the Congress and for our country.

In any event, I have to admit, as Chair, there was one member that I relied on so much. He is the gentleman from California who since 1984 served and continues to serve as the chairman of the Health Committee. And so it is with a great deal of pride that I yield 3 minutes to the gentleman from California (Mr. PETER STARK).

Mr. STARK. Mr. Speaker, today's vote will be the most important of our careers. History will mark which side we're on: providing quality, affordable coverage for all Americans, or the status quo.

I would remind my friend from Wisconsin that former Senator Bob Dole voted against Medicare, and that vote has haunted him ever since. It probably prevented him from becoming President.

Since my first election, I have worked to see that government serves our people. My top priority for 37 years has been to provide quality, affordable health care for all. I wish we had done it sooner, but at my age, you learn to take what you can when you can get it.

The bill is not the bill that many of us would have created on our own. That is the legislative process. The compromise before us today is the right thing to do for the American people.

The bill guarantees health coverage to 96 percent of Americans. It's fully paid for. People who like their coverage indeed can keep it. It reforms health insurance regulation and requires shared responsibility by individuals, businesses, and government. It assures that health care is affordable for lower- and middle-income families. It fills the Medicare prescription drug doughnut hole, and it provides free preventive services in Medicare.

It has the support of consumers, doctors, nurses, senior citizens, children, people with disabilities, farmers, and small business owners—organizations that represent virtually every segment.

In my district, like every other district, Republican or Democrat, I've got 67,000 uninsured people who will be helped; 8,000 people with preexisting conditions; 14,000 businesses will get tax credits; 8,300 seniors will have the doughnut holes filled. And every district in the country has similar numbers. I defy you to go home and tell those people you voted to deny them quality, affordable health care.

I am proud to have helped author this legislation. I encourage each of my colleagues to join me in voting ''yes.'' I can assure you, these guys aren't going to have to pay for it in the future.

□ 1630

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members on both sides of the aisle are reminded not to use guests of the House as props.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Georgia (Mr. LINDER).

Mr. LINDER. I thank the gentleman for yielding.

Mr. Speaker, we have been listening ad nauseam for months from the Democrats, who have been saying that anybody who doesn't support a government takeover of health care is supporting their insurance friends or their friends in the pharmaceutical industry.

Guess who contributes to political campaigns? Lawyers contribute more than all the rest together. To who whom do they give their money? Surprise. Surprise. Ninety-six percent was given to Democrats in this year. Is that why they are left out of the health care reform bill?

Everyone who has looked at this issue for years has said to start with tort reform. Start with tort reform. The three most recent studies all this year said that Americans are spending $200 billion a year on tests and procedures that are unnecessary, defensive medicine, because, if they are not done, the doctors will be sued. That's $2 trillion over 10 years. That would pay for this $1.5 trillion behemoth.

It is ignored except in one fashion: there is mention in this bill that, if your State has already reduced jury awards and has gotten control over tort reform, you will be punished.

Ladies and gentlemen, this is not about health care. This is about rewarding your friends and about punishing your enemies. It has been going on all year, and it is a huge mistake.

Mr. RANGEL. Mr. Speaker, it is my pleasure to yield 1½ minutes to the gentleman from Michigan (Mr. LEVIN). If there is a moral issue, I would like to be on his side.

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, most Americans—and I emphasize that—most Americans want to keep the insurance they have and do not want to lose it because of skyrocketing costs; to be sure they are not denied coverage because of preexisting conditions; and to be sure if they have major illnesses, they are not bankrupted by unaffordable costs. Most Americans also want other citizens to have their health care needs covered by insurance.

Democratic health care reform responds to these concerns, and like Social Security and Medicare, it is as American as apple pie.

Consider this letter from a constituent of mine from Fraser, Michigan: ''I am ashamed to let my family and friends know that I have no health insurance. I have refused hospital treatment I know I needed because I could not afford to pay for any type of medical procedure.''

She closes her letter with this simple message: ''Please don't let anything or anyone stop you from reforming health care. I hope you will think of me. I need you to do the right thing. Health care for all Americans now.''

That's what we are doing: health care for all Americans now.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from California (Mr. NUNES).

Mr. NUNES. Mr. Speaker, as we consider this massive government-run health care bill currently before the House, I would like to remind my colleagues of a few things that have happened over the last year.

We spent $1 trillion to bail out banks, investment companies and car companies. We spent another $1 trillion on a stimulus bill that has yet to produce any jobs as promised. This record spending doesn't count the omnibus spending bill that we had and the fact that we grew our budget to $3.6 trillion all in one year.

If this weren't enough, we are being asked now to create a new trillion-dollar, government-run health care program despite the fact that we can't pay for the two existing government programs that we have today—Medicare and Medicaid. These two programs have at least $62 trillion in debt that this Congress refuses to recognize. Let me repeat that again: $62 trillion in debt that we face with our two existing government-run health care programs. Mr. Speaker, with $1 trillion here and $1 trillion there, pretty soon, you are talking about real money.

What is worse is that, despite all of this spending during record times of high unemployment, this bill will kill American jobs, exporting them overseas. In the meantime, our government leaders continue to run over and grovel to the Chinese to borrow more money to finance the spending.

Mr. Speaker, Rome is burning while this Congress fiddles. This Congress is so irresponsible, so reckless, it's like watching a broke, drunk gambler continuing to double down, just trying to break even.

Vote ''no.''

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval thereof of proceedings or other audible conversations is in violation of the rules of the House.

Furthermore, occupants of the gallery are guests of the House. Those in violation of these rules of the House may be removed.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to the gentleman from the sovereign State of Georgia (Mr. LEWIS), the true voice of justice in this Congress.

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank my chairman, Chairman RANGEL, for yielding.

Mr. Speaker, this is a historic day. As President Kennedy said in his book ''Profiles in Courage,'' there comes a time when men must act according to the dictates of their conscience and not according to political expediency.

We have a mission. We have a mandate. We have a moral obligation to lead this Nation into a new era where health care is a right and not a privilege. Now is the time. Be on the right side of history, the right side of the sick, the right side of the vulnerable. We have been tracked down by the spirit of history. If we fail to act on health care, if we fail to do what we must do, history will not be kind to any of us.

So I say to you, my colleagues: be not afraid. Be not afraid. Be of the courage. The time is always right to do what is right. On this day, at this moment, answer the call of history, and pass health care reform, and pass it today. Pass it now for the people of this country.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. CARTER).

Mr. CARTER. Mr. Speaker, a couple of weeks ago, I was doing a town hall meeting, and I got an email from a friend. He said, There's an old saying: control a man's purse, and you control half the man. Control a man's health, and you control all the man.

We are talking about a massive change in the lives of every human being in America today. That massive change is because we've already turned over to the Federal Government most of our financial system for them to manage it, so they control our purse. This government controls the purse of America, and we have done that this year. It's there. We bailed people out. We are now voting members of financial organizations and businesses, like automobile firms. Now we want to control the American people's purse.

Now we have to ask ourselves: Well, what's going to happen when we do? When we create this great system, how do we know what it's going to look like?

Maybe there's a lot of talk here. I think we've got a fairly independent vision. I want to use this vision, quite frankly, but it's not fair because it's one-sided, and this document is two-sided, but this document printed in smaller font is two-sided. So here is what we have in the way of what the government needs to create for a health care plan.

These are government ideas.

This is the substitute: the people's ideas.

It's the difference, ladies and gentlemen, between liberty and government. You know, this week, a whole lot of people came an awful long way so that they could express their opinions, and they were called radicals.

Vote against this bill.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to a true expert on our country's law system and tax system, the gentleman from Massachusetts (Mr. NEAL).

Mr. NEAL of Massachusetts. Thank you, Chairman RANGEL.

Mr. Speaker, let me stand in support of this health care bill today. Reforming this health care system has not been easy, but we come here today after deliberating for countless years, weeks, months—and as recently as this morning more hours added—because we are building a baseline of health care for the American family.

We've worked hard to reform this health care system because, if we do nothing, family premiums will increase $1,800 a year; and by 2020, 61 million Americans will be uninsured. We have analyzed, and we have debated the details of the bill line by line and section by section.

To the critics, yes, we've read the bill.

For all of the misinformation that has surrounded this legislation, there is a great deal that we all here today agree upon: this bill ends discrimination based on preexisting medical conditions; it limits out-of-pocket expenses for families; it bans lifetime limits on health care coverage that a family with a critically ill child can bump up against in no time at all.

Limiting out-of-pocket expenses is something we do all agree on. Half the bankruptcies in America are health care-related. This bill removes the uncertainties of our health care system for families and for businesses, for young adults who are no longer eligible for their parents' insurance coverage, and for senior citizens in the Medicare part D doughnut hole. This is a solid piece of legislation.

As I close, remember the party that stood with Social Security, and remember the party that stood with Medicare as we proceed to this vote this evening.

Mr. CAMP. Mr. Speaker, I yield 3 minutes to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

Mr. Speaker, one of the issues in the underlying bill allows for the taxpayer funding of abortion, and the leadership of the majority party did see fit to allow Mr. STUPAK of Michigan and others to offer an amendment that would restore what has been a 30-year effort, that no taxpayer funds should be used for abortion.

If that amendment were to pass, Mr. RANGEL, and when this bill comes back from committee and if the House does, in fact, pass the Stupak language of outlawing taxpayer funding for abortion, will you guarantee me, when it comes back, it will be in the bill?

I would be happy to yield.

Mr. RANGEL. Mr. Leader, you've been here long enough to truly understand how this system works.

As soon as we pass this bill, then we would expect the Democratic-controlled Senate to pass their bill. Then we will go into conference, and we will work the will of the majority in the House.

We had no idea that you would expect that a Member, especially one that you spoke in such glowing terms of as you have about me—that you would expect me on this floor, in front of all of my friends and colleagues, to guarantee you anything. I think any Member who gives a guarantee might be in violation of our ethics laws, so I wish you would kind of take a look at this before you would ask these questions.

Mr. BOEHNER. In reclaiming my time, Mr. RANGEL, if the House does, in fact, vote for the Stupak language, in

conference, do I have your guarantee that your vote will be in favor of the Stupak language?

Mr. RANGEL. Well, I haven't normally cut any deals with you as a Republican, but why don't you talk to someone on your level in the House leadership as you have in the past?

Mr. BOEHNER. Reclaiming my time, Mr. Speaker.

Mr. RANGEL. You asked me a question.

Mr. BOEHNER. This is exactly the point I've been trying to make.

While the House is expected to take up the Stupak language later on this evening, language which would outlaw the taxpayer funding of abortion, it's pretty clear that this could be a shell game that's underway, that it gets to pass here in the House, helping to ensure that this bill passes; but we have no guarantees that when it comes back from conference that that language stopping the taxpayer funding of abortion will be in the bill.

□ 1645

Mr. RANGEL. All I am asking, as long as you have been here, have you ever had any Member—

Mr. CAMP. Regular order, Mr. Speaker. Regular order. No time has been yielded.

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York.

Mr. RANGEL. Have you ever gotten a guarantee like that from anybody since you have been here? No.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members will please direct their remarks to the Chair.

Mr. RANGEL. Mr. Speaker, it is my pleasure to yield 1½ minutes to Mr. THOMPSON of California. I thank him for the great contribution he has made to this bill that we present.

Mr. THOMPSON of California. Thank you, Mr. Chairman, for yielding.

Mr. Speaker and Members, for far too long too many Americans have not had access to quality, affordable health care. Because of this legislation, the millions of Americans who don't have health care or who are struggling to pay their health care bills will be able to get the care they need when they need it. Families, small businesses, and individuals will save money.

There will be no copays or deductibles for preventive care services. If you change jobs, you can take your coverage with you. You will not be denied coverage for preexisting conditions and families won't be bankrupted by high medical bills.

The bill will also help inject competition into the marketplace to help bring down the rising costs of health care insurance. The Medicare doughnut hole will be closed and the bill reduces the deficit by at least $30 billion over the next 10 years.

There is still a lot more work to be done, and we are going to fix the doctor reimbursement to ensure the best access for our seniors in regard to getting health care. Today is a historic day for all Americans. It moves us one step closer to quality, affordable health care for all Americans.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Ohio (Mr. TIBERI).

Mr. TIBERI. Mr. Speaker, the American people do not want their health care replaced by government-run health care.

This bill is flawed in many ways. It cuts benefits to seniors. It increases taxes. It's the largest expansion of Medicaid ever at a time when State governments across our land are cutting services. It creates and extends 43 entitlement programs and 111 new offices, bureaus, commissions.

The Ohio State Medical Association that represents doctors in my district is opposed to the bill. They write, ''Medicaid eligibility expansion is a troubling trend for the physician community as payment for these services often fails to cover the cost of providing care.''

They go on to say, the legislation ''lacks many of the critical elements necessary for successfully reforming Americans' health care delivery system and strengthening the physician-patient relationship.''

The bill does not address medical liability reform, which causes defensive medicine to be practiced. Medicare is cut by over $500 billion. Five million seniors could lose the coverage they have today. It turns out that you can't keep what you have if you like it. In fact, one of three seniors in my district could lose the benefits they enjoy today.

I am also concerned about the negative impacts on small businesses and employers. Under the ''pay or play'' mandate in this bill, Mr. Speaker, $135 billion in new taxes will be thrust upon those businesses. This could cause over 5.5 million Americans to lose their jobs.

Mr. Speaker, we have a better way, a better alternative that will lower health care premiums, guarantee health care to affordable health care for those with preexisting conditions, allow States flexibility to provide more coverage, and protect the benefits of our seniors.

Americans deserve better, Mr. Speaker. There is a better way. Let's reject this bill and start over.

Mr. RANGEL. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Nevada (Ms. BERKLEY) and thank her publicly for the great contribution she has made to this bill.

Ms. BERKLEY. I thank the chairman for his kind words and his leadership on this issue.

Mr. Speaker, I rise today in support of this historic piece of legislation that will expand health care coverage to millions of my fellow Americans.

The way we provide health care in this country is unsustainable. In Nevada, the cost of a private family health insurance plan is expected to grow from over $11,000 in 2009 to more than $19,000 10 years from now. If we do nothing, we will reach a point in this country where hardly anyone will be able to afford health insurance.

This bill is good for Nevada. Over 400,000 uninsured Nevadans will be able to get health insurance because of this bill. This bill is good for Nevada's seniors. It closes the doughnut hole, eliminates copays for preventive services and extends the life of Medicare over 5 years.

The bill isn't perfect. It doesn't contain a provision to protect bone density tests that I fought for, and it doesn't fix the Medicare physician payment system, and we must do both. But I support this bill today for the needed reforms that are included. They are very important. It's a great first step.

Faye Schwartzer in Las Vegas, Nevada, this vote is for you.

Mr. CAMP. At this time I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. I thank the gentleman.

Mr. Speaker, the bill before us creates 111 different offices, bureaus, commissions, programs and entitlements, but it only cuts one—Medicare. This bill steals more than $500 billion from our Nation's seniors to fund new entitlement programs for the young, the healthy and the wealthy.

My colleagues in the majority have boldly decided that cutting $500 billion from Medicare is a good idea. They actually are telling seniors that these cuts will improve Medicare in the future.

Well, Grandpa and Grandma might be old, but they are not stupid. You are not going to cut Medicare and tell them that it's a good thing.

The bottom line is that this bill is not real reform. Congress should be strengthening Medicare, not weakening the program. Just look at how bad the Federal Government has been historically in predicting health care costs. This bill will increase health care costs for all Americans and cut Medicare funding. Americans don't believe that yet another trillion-dollar program will cost them nothing.

Mr. Speaker, we all hear Speaker PELOSI say that she is a mother and a grandmother. Like Speaker PELOSI, I too am a mother and a grandmother. I can tell you that my constituents believe that this bill is bad for the middle class, bad for parents and grandparents and, even worse, for future generations.

I cannot support this bill. I urge my colleagues to reject it as well so that we can work together truly on a bipartisan solution. The President's own economic advisors have said that this bill will kill 5.5 million jobs. Americans back home are watching this and saying, What is Congress thinking? Why would they want to further sabotage our economy? This bill clearly is

not what America wants. They want an incremental approach. Nobody is defending health care as we know it. We are saying, let's fix what's broken.

I urge my colleagues to vote against this bill. It is dangerous for our economy. It is not something that every American needs, wants or can afford at this time.

Mr. RANGEL. I yield 1½ minutes to the gentlewoman from Pennsylvania (Ms. SCHWARTZ) and I would like to publicly thank her for the many hours that she put in on H.R. 3200.

Ms. SCHWARTZ. Thank you, Mr. Chairman.

Finding a uniquely American solution to ensure that all Americans have access to meaningful, affordable health coverage has been an unfulfilled goal for decades.

Today we have the opportunity to make this moral and economic imperative a reality. I want to acknowledge the extraordinary leadership of our chairman and of the cooperation of three committees in the House and all of the Members who were so engaged in developing the bill before us today.

The Affordable Health Care for America Act meets the goals of health care reform: enhanced consumer protection for those with health coverage, eliminating preexisting condition exclusions; new, affordable choices for individuals and small business; strengthened Medicare for our seniors with better prescription drug coverage and greater access to primary care; improved delivery of care with better health outcomes for all Americans; and the containment of rapidly rising costs of health care.

It builds on America's public-private system and is paid for, now and into the future. The status quo is unaffordable, unsustainable and unacceptable.

Now is the time to act on behalf of the millions of Americans without insurance and the millions more who are underinsured, on behalf of small and large businesses who struggle every day to pay the rising cost of insurance for their employees, on behalf of seniors. In fact, on behalf of all Americans who worry about our families getting the health care they need and then being able to pay for it, today is a great day for America.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Kentucky (Mr. DAVIS).

Mr. DAVIS of Kentucky. Mr. Speaker, we all agree we need to improve health care quality and increase access, but this bill fails to do so. Republicans know health care reform can be accomplished without raising taxes for families and small businesses, without increasing the size of government, without cutting Medicare benefits.

This week, tens of thousands of Americans traveled to Washington, D.C., to demand a health bill that would increase access, reduce cost, save jobs and keep the government out of our health decisions.

Instead of listening, Democrats squelched over 45 health care bills in favor of a tyrannical bill that cuts senior benefits, creates 118 new agencies, boards and programs, kills jobs and raises taxes by $730 billion.

Unemployment has reached a staggering 26-year high and Speaker PELOSI's health care bill will cost another 5.5 million jobs. Americans don't want reform that comes with higher cost and unemployment.

This is a misguided effort by the majority, making it more complicated and expensive to create jobs. The Northern Kentucky Medical Society and thousands of doctors nationwide are opposed to this bill, H.R. 3962. They know that government takeover of health care will put bureaucrats between doctors and patients.

We can craft responsible health care legislation, and that's exactly what my Republican colleagues have done in H.R. 4038, the Common Sense Health Care Reform and Affordability Act. Our substitute reduces premium costs for every American to make health insurance more affordable and accessible, without raising taxes and without cutting Medicare benefits on our seniors.

Under our bill, insurance premiums are $5,000 cheaper per family than the cheapest Democratic bill. This bill takes waste and costs out of the system instead of adding to it. The Republican bill heeds the pleas of the people without spending $1.3 trillion, without killing jobs and without hurting seniors.

Madam Speaker, H.R. 3962 is not reform; it is tyranny. Give the people health reform, health freedom, and kill this bill.

Mr. RANGEL. Mr. Speaker, I yield 1½ minutes to my friend and leader from the great State of New York (Mr. CROWLEY).

(Mr. CROWLEY asked and was given permission to revise and extend his remarks.)

Mr. CROWLEY. I thank my good friend, the gentleman from New York, for yielding me this time.

I rise today in support of the Affordable Health Care for America Act, which will provide millions of hard-working American families the quality, affordable health care they deserve. In the past decade, the cost of health care for American families has skyrocketed. Premiums have doubled, yet wages remain stagnant at best.

Last year, more than half of Americans postponed care or skipped their medications because they simply could not afford them. The status quo is no longer acceptable nor affordable, and the status quo is changing today. Today Democrats are taking action and delivering to the American people real change, a better, safer, more affordable way of life.

The Affordable Health Care for America Act will give American families peace of mind, peace of mind that health care is not just a luxury for some but an affordable, accessible benefit for all of us.

I urge all of my colleagues to make history today and vote ''yes'' on this bill to make health insurance affordable and accessible for each and every American.

□ 1700

Mr. CAMP. Mr. Speaker, at this time I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Washington State (Mr. REICHERT).

Mr. REICHERT. I thank the gentleman for yielding.

Mr. Speaker, we have heard yesterday's announcement: unemployment eclipses 10 percent. Yet today we are considering a health care bill that will cost even more jobs and will raise taxes on families, on small businesses, on seniors, and takes away freedom.

This bill especially hurts our seniors, our greatest generation, by cutting their benefits, raising their premiums, and, on top of that, taxing wheelchairs, taxing pacemakers, taxing hearing aids.

This bill is not right for America, it is not right for families, it is not right for small businesses, and it is not right for seniors. We need real solutions.

Let's focus on reducing the costs maybe, offer tax incentives, enact medical liability reform, allow people to buy insurance across State lines. These solutions bring lower costs and bring health care to those who really need it.

Mr. Speaker, the most troubling aspect, though, of this bill is that it takes away freedom, and this freedom came through great sacrifice, the sacrifice of men and women throughout the history of this great Nation so that we could choose and live a free life. This bill takes away that freedom, the freedom to choose the health care that is right for you and your family. This bill takes away that freedom, requiring every American to purchase a government-approved health plan, pay a tax, or even go to jail. This bill takes away the freedom of patients to consult with their doctors without government interference. And this bill takes away that freedom, the freedom of our seniors to choose their own health care plan.

So, Mr. Speaker, this is not only a job-killing bill. Mr. Speaker, sad to say, this is a freedom-killing bill.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to the gentleman from New Jersey (Mr. PASCRELL), and thank him for the great job he has done for the committee.

Mr. PASCRELL. Mr. Speaker, no one believes the loyal opposition that Democrats don't care about seniors. Need I provide a history lesson 101 here?

Today is when we must ask ourselves the real reason we came to Congress. Was it to fulfill the hopes of the people, or to take the path of least resistance? The easy thing would be to say the problem is too big, the interests are too aligned, and then maintain the status quo. The hard thing is to bring everybody together, make the compromises that need to be made, and

give the American people true health care reform that will carry our country through for generations.

This is the same choice that was laid before the Members of the 89th Congress when they voted on the creation of Medicare and Medicaid. And where would we be today as a nation had those Members simply succumbed to the difficulty of making real change? Where would we be today? Where would we be in mortality? Where would we be with the seniors who were sick and poor at that time without those two programs?

We are now 40th among the industrial nations in infant mortality. When will we wait to have our consensus? We need this reform. Let us not leave another generation to wonder what we could have been.

Let's pass historic legislation that provides the promise of affordable health care for every American today and the generations to come.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Louisiana (Dr. BOUSTANY).

Mr. BOUSTANY. Mr. Speaker, today we will have a vote on a flawed, massive, and irresponsible health care takeover by government, pushed by Speaker PELOSI and House Democrats, that will cost more than $1 trillion. This bill will increase health care costs for most Americans, increase taxes while Americans struggle to find work, and hurt seniors' quality care.

Mr. Speaker, as a heart surgeon, I saw the amazing innovation in my 20 years in practice in our system. In fact, in the early 1950s, an American surgeon, hopelessly observing the death of a patient from blood clots to the lungs, was inspired and invented the first heart-lung machine that made open heart surgery possible. Many thousands of patients worldwide have benefited from this innovation, this innovation right here in the United States, innovation that will be stifled by the Pelosi health care bill.

There is another way. We can do better. House Republicans have solutions that will lower costs by creating real choice and competition. We will help those with preexisting conditions to get meaningful health care coverage, we will preserve U.S. leadership in medical innovation and education, and we will reduce frivolous lawsuits in medicine that needlessly drive up the costs for families.

As a heart surgeon, I know that we can achieve real health care reforms to bring down costs. But the Democrats' current bill will only lead to higher costs for millions of Americans and destroy what is currently working in our system.

There is a better way. There is a different way. There is a way to lower health care costs, help more people achieve a high quality doctor-patient relationship in this country and improve health care for all Americans.

Vote down this bill and support the Republican plan.

Mr. RANGEL. Mr. Speaker, I now yield 1½ minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, passage of this bill will move us closer to the realization that all men, women, and children in this country can have access to quality health care. It will reduce the waiting time in emergency rooms and shorten the length of time you have to wait to see a doctor. It makes it possible for people to have health insurance who have never had any before in their lifetime and to see a doctor on a regular basis. It recognizes the needs of people with disabilities. It seriously increases the number of community health centers, protects disproportionate share and teaching hospitals, and promotes health awareness and education. But, most importantly, it prolongs and enhances life, as well as its quality.

This is the most significant health legislation passed in this country since Medicare and Medicaid. Residents of my district have been calling all day asking that I would vote for them, that I would vote for Illinois, that I would vote for America. I tell them, yes, I will, because I believe that health care ought to be a right and not a privilege.

I wanted a single-payer system, but I will vote for H.R. 3962 because it is good for Illinois, it is good for me, it is good for you, and it is good for America.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Nevada (Mr. HELLER).

Mr. HELLER. Mr. Speaker, I thank the ranking member for his exceptional hard work in producing a Republican alternative that does not raise taxes, raise premiums, increase our debt or increase health care costs.

In a recent article, the Democratic leadership stated that getting votes today will be easier because Democrats want to go home.

Mr. Speaker, the Pelosi health care bill will cost Americans more than 5 million jobs. Despite national unemployment at 10.3 percent, and in my home State of Nevada, over 13 percent unemployment, we are moving forward with this bill. For the majority, this is fine, if Members of Congress get to go home.

This legislation raises billions in new taxes on small businesses and increases health care premiums by $15,000 per family on average. But, as I said, as long as the majority gets to go home, this doesn't matter.

This bill cuts $500 billion from Medicare, affecting more than 20,000 seniors in my district and over 100,000 Statewide, and also avoids meaningful medical liability reform. But the majority will support it, because they get to go home.

This bill's individual mandates will result in 9 million Americans paying a new tax or facing criminal penalties. These penalties include $250,000 fines and/or 5 years in jail for failure to pay the tax. However, this doesn't matter, as long as the majority gets to go home today.

Mr. Speaker, this bill lacks enforceable citizenship verification provisions. As many as 8.5 million illegal immigrants will be eligible for taxpayer-subsidized health care under this legislation. But, of course, if the majority gets to go home, it simply doesn't matter.

Yet the height of hypocrisy is that Members are not required to participate in this government-run health care program.

Unfortunately, the strategy to pass this massive bill hinges upon Members of Congress wanting to go home, instead of passing legislation that will help the American people.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to a hardworking member of the Ways and Means Committee from the sovereign State of New York (Mr. HIGGINS).

Mr. HIGGINS. Mr. Speaker, the American health care industry is a $2.5 trillion industry. It represents 17 percent of the American economy, as measured by the gross domestic product. Yet our outcomes, according to the World Health Organization, are pathetically falling behind. We are 37th in overall quality. Unacceptable in America. We are 41st in infant mortality. That means in 40 other countries, from birth to 1 year of age, kids live by a higher percentage than they do in the United States. Unacceptable in America. We are dead last of any industrialized country in preventable deaths. Unacceptable in a good and generous Nation.

This is a uniquely American problem with a uniquely American solution. We look to not-for-profit plans, like the Cleveland Clinic, the Mayo Clinic and Johns Hopkins. They are early adapters of new innovation, and they are providing the highest quality health care, not only in the Nation, but throughout the world, at the lowest possible cost. That is the health care that I want for my family, that is the health care that I want for my community, and that is the health care I want for my Nation.

We have been debating this issue not for seven months, but for seven decades. It is time for change. I understand that reform is tough. The reformer, said Machiavelli, has enemies in all those who profit by the older order, and only lukewarm defenders in all those who would profit in the new order. On health care, most Americans are rooting for the reformer.

Mr. CAMP. Mr. Speaker, at this time I yield 2 minutes to a distinguished Member of the Ways and Means Committee, the gentleman from Illinois (Mr. ROSKAM).

Mr. ROSKAM. I thank the gentleman for yielding.

Mr. Speaker, if you are at home and you are sort of flipping channels between the football games and C–SPAN,

and you flipped on and only heard the majority party, you would think, wow, what a great plan. I mean, really, you would think people are just going to fall all over themselves, and all these adjectives and declarative statements just sound wonderful. Until you look inside that bill and you find handcuffs.

Now, I am not talking about figurative handcuffs. I am talking about criminal penalties; criminal penalties that have been mentioned by the gentleman from Texas, criminal penalties that have been mentioned time and again on this floor. We have heard from the best and the brightest all afternoon, and not a one of them have answered why it is you have to criminalize people to coax them into a plan that is fabulous. It makes no sense.

And these aren't my words. This is actually coming from the Joint Committee on Taxation, in a letter that was written, ironically, with Chairman CHARLIE RANGEL as the chairman of that committee, released 48 hours ago, that says in fact if you don't comply with the individual mandate, what happens to you? You can be subject to 5 years in prison and you can be subject to a quarter of a million dollars in fines.

□ 1715

And the other side, with all due respect, with all the adjectives and all the flourishing speech, has failed to answer that question.

I submit to you, if we listen today, if we listen to the remainder of this debate, they will be silent in terms of a good answer as to why it is you need to criminalize people to coax them into a plan. It's a failure, and we ought not stand for it.

The small businesses, the entrepreneurs, and the self-employed that this would have an impact on, they say, ''Look, don't criminalize us. Give us relief. Let us purchase across State lines.'' Not in the Democrats' bill. ''Give us real tort reform, real liability reform.'' Not in the Democrat bill in any substantive way. ''Let us purchase and work together to pool to lower costs down.'' The right to remain silent shouldn't be the word from the government.

Mr. RANGEL. At this time, I yield 90 seconds to the gentleman from Kentucky (Mr. YARMUTH).

Mr. YARMUTH. Mr. Speaker, 3 years ago today, the citizens of Louisville, Kentucky, sent me to this body. They sent me here largely to help bring us to this moment.

I was sent by a recent college graduate who had to give up her coverage under her parents' health insurance policy and couldn't get her own coverage to cover her lifelong allergic condition.

I was sent by the family of a 10-year-old little boy who wrote me, begging for help to help pay for the $50,000 they have to pay annually to care for their autistic brother.

I was sent by the Louisville woman whose insurance was dropped in the middle of her cancer treatment.

I was sent by thousands of seniors, struggling to pay their prescription drug costs.

I was sent by people like the local realtor who is trying to figure out right now how to pay his next year's insurance bill he just received with a 32 percent increase.

Today is the day those Americans get the help they have been praying for. It is the day we take a giant step toward that more perfect Union that we all seek. I am very proud to be a part of this historic day, and I am also very proud for the all-too-patient citizens of America who sent me here, along with many of my colleagues, in 2006 to cast votes for the Affordable Health Care for Americans Act.

Mr. CAMP. Mr. Speaker, at this time, I yield 1 minute to the gentlewoman from Michigan (Mrs. MILLER).

Mrs. MILLER of Michigan. Mr. Speaker, during the past year, the Democratic majority has passed so many bills that have done absolutely nothing to help our economy. Instead, they've raised taxes, they've exploded the deficit, and they actually have killed off jobs. Then, yesterday, the national unemployment rate went up past 10 percent—actually, to 10.2 percent, with no end in sight.

So it is incredible that today this House may pass a job-killing, tax-hiking, deficit-exploding government takeover of our health care. And one of the most disingenuous things that has been said is that if you like your current health care, that you can keep it. Well, not so fast.

In my county, Macomb County, Michigan, the Chamber of Commerce just did a survey of all of their members. They asked them that if, rather than continuing to provide good health care plans for their employees, they would instead take the 8 percent penalty that is included in this bill, and guess what? No surprise. The overwhelming majority said they would of course dump their employees out into the public plan.

Mr. Speaker, we are going to have a complete government takeover of our health care system faster than you can say, ''This is making me sick.'' Vote ''no.''

The SPEAKER pro tempore. The gentleman from Michigan has 8 minutes remaining. The gentleman from New York has 14½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I would like to yield 1 minute to the Congresswoman from California (Ms. LEE), who is the chairperson of the Congressional Black Caucus and has done such a great job on the question of diversity as well as other parts of the bill for women.

Ms. LEE of California. Mr. Speaker, on behalf of the Congressional Black Caucus, I rise in strong support of this bill. Known historically as the conscience of the Congress, we recognize that it is our moral responsibility to pass this today.

I want to thank the gentleman and commend him and the other Chairs of the tri-committees as well as our leadership and our Speaker for bringing us to this point today.

The strong public option in this bill will provide our constituents with the choice and competition they want. It will help improve health equity and help eliminate health disparities, and this bill recognizes that an ounce of prevention is worth a pound of cure. It will help people who choose to keep their private plans by limiting annual rate increases by insurance companies.

Today's historic vote is another step forward in our quest for social justice. It really is about life and death, but it's not the end of the process. The Congressional Black Caucus will keep fighting until a final bill is on the President's desk.

Today, finally, health care will become a basic human right for all, rather than a privilege for the few. We all have been called today for such as this. Let us rise to the occasion and vote ''yes'' on affordable health care for all.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentlewoman from Oklahoma (Ms. FALLIN).

Ms. FALLIN. Mr. Speaker, the American people understand the need for health care reform. They just don't want socialized medicine. They don't want the Federal Government taking over our health care decisions, taking away our freedoms of choice about health care. They don't want more Federal deficit spending on the backs of our children and future generations of our children, and they don't want more taxes upon small business, especially in this recession.

They don't like the Federal Government taking away our freedoms guaranteed under this Constitution, and they don't want the Federal Government interfering in our States' rights. They don't want unfunded mandates upon the States, and they don't want government-funded taxpayer abortions upon our families.

Mr. Speaker, men and women have fought for our freedoms for this Nation for generations, but this health care bill will change the face of our Nation and put our Nation on a trajectory of a Federal Government takeover in so many areas of our freedoms and our lives.

Let's reject this health care bill, and let's start all over and pass real, meaningful health care reform.

Mr. RANGEL. I yield 1 minute to the gentlewoman from New York, Congresswoman VELÁZQUEZ.

(Ms. VELÁZQUEZ asked and was given permission to revise and extend her remarks.)

Ms. VELÁZQUEZ. For too long, millions of Americans have suffered without access to the medical treatment they need. Right now, as we debate this measure, too many Americans are worrying about how they will find health care coverage if they lose their jobs. On this day alone, 14,000 Americans will lose their coverage, and millions of other citizens, including one in every

three Hispanics, lack health insurance coverage.

Today all of that changes. This is the moment. No longer will insurance companies abandon Americans when they most need help. This bill will end the practice of denying Americans coverage because of preexisting conditions. The 36 million uninsured Americans will finally have coverage. Choice, competition, and transparency will be brought to the insurance market, meaning better care at lowered costs.

I say this to my colleagues: It has been too long. Let us pass this bill.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. CRENSHAW).

Mr. CRENSHAW. Mr. Speaker, a lot of the men and women that I represent in northeast Florida are members of the military, and we've been working for 15 years to make sure they have adequate health care. They deserve it. They defend us every day.

They asked me, How is this new Democratic plan going to affect my TRICARE and my TRICARE for life? The answer is nobody really knows what this slippery slope with the public option is going to do to existing coverage. If you take this Democratic plan, you will see it's complicated, 2,000 pages long. It's unproven. It's untested. It's filled with uncertainty.

At the end of the day, this Democratic plan is a dangerous experiment on the backs of the American people without their consent. If this were the medical field, that would be unethical. It would be malpractice. There is a better way, Mr. Speaker. There is a better way.

Mr. RANGEL. I yield 1 minute to the gentlewoman from Michigan, Congresswoman KILPATRICK.

Ms. KILPATRICK of Michigan. I thank the gentleman for yielding.

Mr. Speaker, this is a historic day. Choice, competition, quality, and peace of mind. I want to commend the Speaker for her leadership and our chairman in our caucus for putting together a bill that will help American families.

The 36 million Americans who do not now have insurance will be insured. Your premium costs will go down. The quality of all insurance will be increased. No longer will insurance companies be able to examine and cut you off when you get ill. Prescription drugs will be cheaper. The AARP supports this bill. Medical doctors and nurses support this bill. The Consumers Union supports this bill. The UAW supports this bill.

It's a great historical day for our country. I predict it will be, as we go forward, as strong and as popular as Social Security, Medicare, and now our new national health care program.

Thank you. Thank you, Madam Speaker. Thank you, Democrats, for standing strong.

Mr. CAMP. Mr. Speaker, at this time, I yield 1 minute to the gentlewoman from West Virginia (Mrs. CAPITO).

Mrs. CAPITO. Mr. Speaker, I rise today to voice the concerns of my constituents who believe the Speaker's trillion-dollar 1,990-page bill is simply the wrong solution for West Virginia's families. We were told that under the President's plans, those who like their health care would be able to keep it. Well, we now know that is simply not true. It is certainly not true for the 72,000 West Virginians on Medicare Advantage who will see the program slashed by $170 billion under this plan.

Consider one of my elderly constituents from Dunbar, West Virginia, who called just today. She relies on the enhanced benefits of Medicare Advantage to cover her rheumatoid arthritis and her diabetes. She suffered a stroke, a brain aneurysm, and she is on more than a dozen prescriptions. She relies on these services, and she fears that this bill will put them at risk. Sadly, she is right, because this bill will change her health care.

Mr. Speaker, we need health care reform, but we can do better than this.

The SPEAKER pro tempore. The gentleman from Michigan has 5 minutes remaining. The gentleman from New York has 11½ minutes remaining.

Mr. RANGEL. Thank you. I yield 1 minute of that to the gentleman from the great State of New York, GREGORY MEEKS.

Mr. MEEKS of New York. The camera of history is rolling, and I am so happy to play a part in it, because just as we created history in the thirties with Social Security and in the sixties with Medicare, we will create history tonight in passing H.R. 3962.

Dr. King once asked the question, How long? Well, because of H.R. 3962, how long before all Americans have access to affordable and quality health care? Not long. How long before we end discrimination for preexisting conditions? Not long. How long before we ensure that no Americans fear bankruptcy or financial ruin due to illness? Not long. How long before we close the doughnut hole, helping all of our senior citizens? Not long. How long before we begin to control the escalating prices of insurance and health care? Not long. How long before all Americans, all of us, can have access to quality health care? Not long.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, what's in this 2,000-page monstrosity that's costing the taxpayers over $1 trillion in costs? Well, we're going to see tax increases of $800 billion, and $500 billion in cuts from Medicare.

Well, take a look on page 94. Section 202(c) prohibits the sale of private health insurance policies beginning in 2013, forcing individuals to purchase coverage through the Federal Government.

On page 225, however, section 330 permits, but does not require, Members of Congress to enroll in government-run health care.

Page 122, section 233(a)(3) requires the commissioner, a new health insurance czar, to issue guidance on best practices of plain language writing. This from the same people who wrote this 2,000-page health care bill.

Page 183, section 305(a) gives the commissioner the power to enlist appropriate entities, like Planned Parenthood and ACORN, to engage in outreach to specific vulnerable populations about the bill's new programs.

Oppose this bill.

Mr. RANGEL. Mr. Speaker, at this time, I yield 1 minute to Congressman CONYERS, the distinguished dean of the Congressional Black Caucus, senior Member of this great House of Representatives, and someone that had indicated his concern about health care from many, many years ago.

□ 1730

Mr. CONYERS. Thank you, Chairman RANGEL, and all of our colleagues that have supported single-payer health care. Eighty-six other Members are now working to make sure that we get this bill passed. I single out my colleagues DENNIS KUCINICH and ANTHONY WEINER for their particularly effective work.

But I want to say that this is the same battle that some people went through when we passed Social Security. We had the same naysayers. The same people when we passed Medicare, the same naysayers. The same people when we passed Medicaid, the same naysayers. And now we try to reform health care today, and what do we get? The same people saying ''no'' again.

So I'm proud to bring all of the support that I can to make sure that this bill becomes law, that more people are covered, and that preexisting conditions no longer will be an excuse to get rid of people.

Mr. CAMP. Madam Speaker, at this time I yield 1 minute to the gentleman from Georgia (Mr. KINGSTON).

Mr. KINGSTON. I thank the gentleman for yielding.

Madam Speaker, what we have today is another Pelosi plan for America.

But let's remember the Pelosi plan for jobs: an $800 billion stimulus plan that caused unemployment to go from 8.5 percent to over 10 percent.

Let's remember the Pelosi plan for automobiles: Cash for Clunkers, a $3 billion program that even the Democrats agreed did not work and was killed after 3 weeks.

The Pelosi plan for fiscal discipline: a $1.4 trillion debt this year, the highest in history.

And let's don't forget the Pelosi plan for national security: dithering in Afghanistan.

Now we have the Pelosi plan for health care: it kills small businesses and jobs. It raises taxes. It raises premiums. It cuts Medicare. It takes away your current health care coverage and spends $1 trillion.

Vote ''no'' on the Pelosi plan for a government takeover of health care and join the bipartisan Members of this Congress who plan to promote an alternative which is far better.

Mr. RANGEL. Madam Speaker, I yield for the purpose of making a unanimous consent request to Mr. FALEOMAVAEGA, my friend from Samoa.

(Mr. FALEOMAVAEGA asked and was given permission to revise and extend his remarks.)

Mr. FALEOMAVAEGA. Madam Speaker, God is good. I rise in full support of the health care needs of all our fellow Americans. God bless America.

Madam Speaker, I rise in strong support of H.R. 3962, legislation to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes. This bill will control rising medical costs and also extend health care coverage to uninsured American citizens throughout the United States and its Territories.

I want to thank Speaker NANCY PELOSI for her leadership and my colleagues in Congress for their support on this important bill. Especially, I extend my gratitude to the Chairmen of the House Committee on Energy and Commerce, Congressman HENRY WAXMAN; and the House Committee on Ways and Means, Congressman CHARLES RANGEL for listening to the concerns of the Territories and for their willingness to work with the Territorial delegates on resolving their concerns.

I also want to commend my fellow Territorial delegates for their hard work and efforts, in working hand-in-hand to reduce health disparity facing the Territories. I especially want to recognize Congresswoman DONNA CHRISTENSEN for her work in the House Committee on Energy and Commerce, Congressman PEDRO PIERLUISI and Congressman GREGORIO SABLAN for their advocacy in the House Committee on Education and Labor and to Congresswoman MADELEINE BORDALLO for her leadership as the Chairwoman of the Congressional Asian Pacific American Caucus Healthcare Task Force.

Madam Speaker, the Affordable Health Care for America Act, or H.R. 3962, will improve health care for Americans living in the insular areas. Under the provisions of this legislation, from FY2011 through FY2019, American Samoa will receive additional Medicaid funding in the amount of $239.5 million. Moreover, its Federal Medical Assistance Percentage (FMAP) will be raised to the highest FMAP applicable to any of the 50 States and District of Columbia. As a result American Samoa will assume an FMAP no less than 75 percent, the FMAP for Mississippi which has the highest among the 50 States.

American Samoa will also work together with the Secretary of Health and Human Services on a plan to transition the Territory to full parity by 2020. And to make this transition, the Secretary will also assist to make appropriate modifications to the Territory's existing Medicaid programs. This will require comprehensive assessment of the existing Medicaid program and health care services in American Samoa.

I am pleased that American Samoa and the insular areas will have the opportunity to become part of the Exchange program, the centerpiece of the Health Care Reform legislation. Again I thank my Territorial delegates for their hard work to ensure that Congress continues to recognize the need and unique set of circumstances we have in the Territories. To help carry out the Exchange program, $300 million is to be allocated among American Samoa, the CNMI, Guam, and the USVI, based on consultation with the Secretary of Health and Human Services. If American Samoa or any Territorial government chooses not to join the Exchange, its allocation will be added instead to that Territory's Medicaid funding.

Madam Speaker, H.R. 3962 will bring much needed improvement to the health care system in American Samoa. The fact of the matter is rising medical costs and limited health care coverage, exacerbated by American Samoa's remote location and exponential rate of chronic diseases, have led to a high number of people in the Territory with minimal or no access to quality health services. Indeed, findings from the American Samoa Health Survey conducted in 2005 estimated only 25 percent of the population have insurance. Subsequently, there is a tremendous need to address these concerns in a viable health care policy for the Territory.

For this reason, in a letter sent June 22, 2009, I wrote members of the Fono (American Samoa Legislature) to address the need to improve the health care system in the Territory. I specifically requested that the Fono should take advantage of the report from the Coverage for All in American Samoa (CAAS) project, which includes policy recommendations on ways to improve the Territory's health care system.

I commend the American Samoa Government especially the Office of the Lieutenant Governor and staff for their dedication and commitment to the CAAS project that was completed in 2007. I also want to commend the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) for committing total funding of $1.2 million from 2004 to 2007 to complete the CAAS project. My hope is for the American Samoa Government to follow through on the policy recommendations in the CAAS report and adopt the framework for health care reform that is now in place and supported by H.R. 3962.

The Affordable Health Care for America Act, H.R. 3962, carries with it our expectations and hopes for quality and affordable health care for our people and with it a commitment; a commitment to ensure that every American is provided quality health care that they are entitled to and to receive health services that they so critically need.

I urge my friends and colleagues to support H.R. 3962 and pass this historical health care reform legislation.

Mr. RANGEL. I yield myself 2 minutes.

This is it for the members on the Ways and Means Committee and others that have demonstrated such outstanding leadership to be a part of history.

It's unfortunate that we were unable to create an atmosphere of bipartisanship because, certainly, the 40 million people that are without health insurance, we can't distinguish between those who are Republicans and those who are Democrats. Clearly, we had enough information of the number of people that were in the congressional district, all of our congressional districts, that had no insurance at all.

I am more than certain that my colleagues on the other side of the aisle have heard the very same stories we have: people who thought they were insured and they were not; people who wanted insurance and they would not insure them because they had some condition; other people who worked hard every day of their lives, but were not given insurance and they can't afford to buy it.

No, this isn't the Pelosi plan. This is a plan for all America, a plan to make us proud to know that our country is concerned about us and our children and our grandchildren. And, yes, the American Medical Association, AARP, and everyone is throwing papers around. But these are the groups, the national groups, that have asked America and this Congress to step up and fulfill our responsibility.

And it's not just for our constituents. It's for our great country, to have her as strong as she can be, to be able to know that we can compete with any other nation no matter what part of the world that we're in; and that our workforce will not only be educated and talented in order to compete, but we will be healthy.

Every industrialized country takes care of their people. It's not a political thing. Certainly here it's not a Republican or Democratic thing. It's, Are we going to be healthy? Are we going to be strong? Are we going to be certain that when you count America, count her among the healthy.

Madam Speaker, I want to bring to the floor an outstanding Member of Congress who is the subcommittee Chair on the Education and Labor Committee. As you know, three committees had jurisdiction and Education and Labor had jurisdiction. We had three chairmen. But we had one subcommittee chairman who has just been outstanding. He's been a friend of those without insurance, a friend of those who look forward to this bill's being passed.

So it is with great distinction that I yield the balance of my time to Mr. ROBERT ANDREWS from New Jersey, and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore (Ms. EDWARDS of Maryland). Without objection, the gentleman from New Jersey will control the balance of the time.

There was no objection.

Mr. CAMP. Madam Speaker, at this time I yield 1 minute to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Madam Speaker, this is well intended. But you read section 501, and it basically says if you make too much to get free health care but you make too little to be able to buy it, you're going to get taxed under this bill. It means well. But it does damage.

For those who have paid into Medicare for 40 years or so, who expected to have it, they get cut hundreds of billions of dollars, but illegals are going to get covered. Come on now.

In the 1960s they meant well with the Great Society, but they offered a check for every child a woman could have out

of wedlock. Meaning well, wanting to help them, but they lured them into a rut with no way out, and they came to my court to be sentenced.

We hurt people when we do the wrong things. For the Declaration of Independence, our Founders pledged their lives, their fortunes, their sacred honor. This is a ''declaration of dependence'' that pledges Americans' lives, Americans' fortunes, and there is no honor in that.

Mr. ANDREWS. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, the people of the country and Members of the House deserve a vigorous debate. They also deserve an accurate record. And I think the time has come to begin to clarify and correct some of the series of assertions that have been made here that are simply not correct.

There was an assertion made from the minority side a few minutes ago that no one knows what will happen to those who are on TRICARE or veterans health benefits. The gentleman may not know, but we do. Nothing will change for a person under TRICARE or veterans benefits if they do not wish to have it changed.

There was a statement made on the other side that the bill will ''cover illegal aliens.'' That is incorrect. There is no subsidy and there is no coverage for an undocumented person.

There have been numerous statements made on the other side that there will be massive tax increases on the American people. Here is the fact: the fact is that there is a surtax in this bill that helps to pay for coverage of uninsured people and for better quality care. It affects the top .3 percent of households in this country. If you're an individual and you make more than $500,000 a year adjusted gross income, if you're a couple and you make more than $1 million a year adjusted gross income, it affects you.

The statement has been made repeatedly the bill will add to the deficit. That's not the truth. That's not what the Congressional Budget Office says. They say the contrary. They say that the net effect of this bill is it will reduce the deficit in the first 10 years by in excess of $100 billion and that in the second 10 years, the bill will reduce the deficit by somewhere in the neighborhood of one-quarter of 1 percent of GDP.

The statement has been repeatedly made that it is a crime not to have health insurance. Here's the accurate statement: because there is a penalty imposed on individuals who don't meet the individual mandate, and, by the way, that individual mandate has within it very generous subsidies and it has a hardship exemption, but it has been said it is a crime not to have health care. That is not accurate. It is a crime to willfully and intentionally evade taxation, just as it is with every other tax.

It has been said this is a government takeover of health care. That is false. This is a consumer takeover of health care. And those who would be apologists for the insurance industry don't like that. The American people do and will.

Madam Speaker, I reserve the balance of my time.

Mr. CAMP. Madam Speaker, at this time I will place in the RECORD a letter from the Joint Committee on Taxation, which on page 3 indicates that both misdemeanor and felony penalties with imprisonment of up to 5 years will be imposed.

CONGRESS OF THE UNITED STATES,
JOINT COMMITTEE ON TAXATION,
Washington, DC, November 5, 2009.

Hon. DAVE CAMP,
House of Representatives,
Washington, DC.

DEAR MR. CAMP: This is in response to your request for information relating to enforcement through the Internal Revenue Code (''Code'') of the individual mandate of H.R. 3962, as amended, the ''Affordable Health Care for America Act.'' You specifically inquired about penalties for a willful failure to comply.

TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE

H.R. 3962 provides that an individual (or a husband and wife in the case of a joint return) who does not, at any time during the taxable year, maintain acceptable health insurance coverage for himself or herself and each of his or her qualifying children is subject to an additional tax. The tax is equal to the lesser of (a) the national average premium for single or family coverage, as applicable, as determined by the Secretary of Treasury in coordination with the Health Choices Commissioner, or (b) 2.5 percent of the excess of the taxpayer's modified adjusted gross income over the threshold amount of income required for the income tax return filing for that taxpayer. This tax is in addition to both regular income tax and the alternative minimum tax, and is prorated for periods in which the failure exists for only part of the year. In general, the additional tax applies only to United States citizens and resident aliens. The additional tax does not apply to those who are residents of the possessions or who are dependents, nor does it apply to those whose lapses in coverage are de minimis or those with religious conscience exemptions. The additional tax does not apply if the maintenance of acceptable coverage would result in a hardship to the individual or if the person's income is below the threshold for filing a Federal income tax return.

RANGE OF CIVIL AND CRIMINAL PENALTIES FOR NONCOMPLIANCE

You asked that I discuss the situation in which the taxpayer has chosen not to comply with individual mandate and not to pay the additional tax. The Code provides for both civil and criminal penalties to ensure complete and accurate reporting of tax liability and to discourage fraudulent attempts to defeat or evade tax. Civil and criminal penalties are applied separately. Thus, a taxpayer convicted of a criminal tax offense may be subject to both criminal and civil penalties, and a taxpayer acquitted of a criminal tax offense may nontheless be subject to civil tax penalties. In cases involving both criminal and civil penalties, the IRS generally does not pursue both simultaneouly, but delays pursuit of civil penalties until the criminal proceedings have concluded.

The majority of delinquent taxes and penalties are collected through the civil process. In determining whether a penalty applies along with an adjustment to a tax return, the examining agent is constrained not only by the applicable statutory provisions, but also by the written policy of the IRS not to treat penalties as bargaining points but instead to develop the facts sufficiently to support the decision to assert or not to assert a penalty. The goal is consistency, fairness and predictability in administration of penalties.

If the government determines that the taxpayer's unpaid tax liability results from willful behavior, the following penalties could apply.

CIVIL PENALTIES

Section 6662(a)—an accuracy related penalty of 20 percent of the underpayment attributable to the health care tax, based on negligence or disregard (the former includes lack of a reasonable attempt to comply and the latter includes any intentional disregard of rules or regulations) or substantial understatement, if the understatement of tax is sufficiently large.

Section 6663—a fraud penalty of 75 percent of the underpayment, if the government can prove fraudulent intent to avoid taxes by clear and convincing evidence.

Section 6702—a $5,000 penalty for taking a frivolous position on a tax return, if the underpayment is intended to delay or impede tax administration and the return on its face indicates that the self-assessment is substantially incorrect.

Section 6651—delinquency penalty of .5 percent of the underpayment, each month, up to a maximum of 25 percent of the underpayment.

CRIMINAL PENALTIES

Prosecution is authorized under the Code for a variety of offenses. Depending on the level of the noncompliance, the following penalties could apply to an individual:

Section 7203—misdemeanor willful failure to pay is punishable by a fine of up to $25,000 and/or imprisonment of up to one year.

Section 7201—felony willful evasion is punishable by a fine of up to $250,000 and/or imprisonment of up to five years.

APPLICATION OF PENALTIES UNDER CURRENT PRACTICE

The IRS attempts to collect most unpaid liabilities through the civil procedures described above. A number of factors distinguish civil from criminal penalties, in addition to the potential for incarceration if found guilty of a crime. Unlike the standard in civil cases, successful criminal prosecution requires that the government bear the burden of proof beyond a reasonable doubt of all elements of the offense. Most criminal offenses require proof that the offense was willful, which is a degree of culpability greater than that required in a civil penalty cases. For example, a prosecution for willful failure to pay under section 7203 requires proof beyond a reasonable doubt both that the taxpayer intentionally violated a known legal duty and that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty applies unless the taxpayer can establish reasonable cause and lack of willful neglect with respect to his failure to pay.

Criminal prosecution is not authorized without careful review by both the IRS and the Department of Justice. In practice the application of criminal penalties is infrequent. In fiscal year 2008, the total cases referred for prosecution of legal source tax crimes were as follows.

Investigations initiated—1,531.

Indictments and informations—757.

Convictions—666.

Sentenced—645.
Incarcerated—498.
Percentage of those sentenced who were incarcerated—77.2.

Of the 666 convictions reported above for fiscal year 2008, fewer than 100 were convictions for willful failure to file or pay taxes under section 7203. Civil penalties outnumber criminal penalties imposed. For example, in fiscal year 2008, compared to the 666 convictions, approximately 392,000 accuracy related penalties were assessed on individual returns. Also in fiscal year 2008, the IRS assessed 5,502 penalties under section 6702 for frivolous positions taken on returns.

I hope this information is helpful for you. If I can be of further assistance, please contact me.

Sincerely,

THOMAS A. BARTHOLD.

Madam Speaker, at this time I yield 1 minute to the gentleman from Texas (Mr. POE).

Mr. POE of Texas. Madam Speaker, in my prior life I was a judge for 22 years. I tried only criminal cases.

This bill forces everyone that can to buy insurance whether they want to or not. If they don't, they're taxed. But that tax is really a fine. Be that as it may, if they don't pay the fine, they're in violation of the IRS Code and they can pay another $250,000 fine and go to a Federal penitentiary for 5 years.

That is government oppression of the people, forcing them to buy insurance whether they want to or not. That is repressive government control, and that's the way that I see it. If they don't submit, they are forced to go to jail.

You know, this bill is about government control. It's not about choice. It's oppression. It's not about liberty. The Constitution starts out with ''We the people.'' If this bill passes, especially that section, let's scratch out ''We the people'' and write in the phrase ''We the subjects of Big Government.''

And that's just the way it is.

Mr. ANDREWS. Madam Speaker, I'm pleased at this time to yield 1½ minutes to the gentlewoman from Ohio (Ms. FUDGE), who's one of the authors of the small business provisions in the bill.

Ms. FUDGE. There comes a time, Madam Speaker, when we must choose that which benefits the greater good or look for selfish reasons to support the status quo. Now is that time and I choose the greater good.

When I go home, Madam Speaker, I will be able to say that I was asked to make health care more affordable and I said ''yes.'' This bill makes health care affordable for 36 million more Americans by ensuring that working-class citizens will never have to pay more than 12 percent of their income on health care premiums and that people whose incomes are 400 percent of poverty or less will receive their premiums in the form of subsidies. More than 163,000 households in my district alone will benefit from these subsidies.

When asked to increase access to care, I said ''yes.'' ''Yes'' to the people of America who will no longer worry about being denied coverage because of preexisting conditions. ''Yes'' to the people of America whose families can now have regular checkups and free preventative care. Madam Speaker, I said ''yes'' to those who for the first time will have a family doctor instead of using the emergency room for routine matters.

When asked to help the laid-off worker, the small business owner, the working poor, and those who can't make ends meet in this very struggling economy, I said ''yes.'' When asked to ensure that those who have health care today but may be dropped tomorrow are taken care of, I said ''yes.'' When asked to exhibit the courage needed to fight for change, I said ''yes.''

When the history of the 111th Congress is written, I choose to be in that number that said ''yes'' to the people of America.

□ 1745

Mr. CAMP. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. ROHRABACHER).

Mr. ROHRABACHER. Madam Speaker, this attempt at sliding Americans into dependence on a government-controlled health care system brings bait-and-switch to a new low. We have heard about the flaws of our current health care system: high cost; lack of portability; lose a job, lose insurance; and discrimination against those with preexisting conditions. Yes, many of the heart-wrenching stories we are hearing to justify this legislation are real. But correcting those maladies only requires specific reform. It doesn't require transforming health care in America into a bureaucratically managed health care system that will cost hundreds of billions of dollars more, including billions to provide health care for illegal aliens while at the same time cutting Medicare by hundreds of billions of dollars.

This so-called reform will destroy the freedom of the American people to make health decisions with their doctor and the doctor of their choice. It will transform our system rather than reform it, and what we will end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

Mr. ANDREWS. Madam Speaker, nurses make a great contribution to our health care system, and a gentlewoman who is a nurse has made a great contribution to this bill. I yield 2 minutes to the gentlewoman from New York (Mrs. MCCARTHY).

Mrs. MCCARTHY of New York. I thank my colleagues, Mr. ANDREWS, and I also thank GEORGE MILLER for also working with us.

We have known for years that we have a shortage of doctors, especially primary care doctors, and we have had a shortage of nurses. This bill is going to help that.

You know, when we talk and I hear some of the charges coming from the other side, I am wondering where have I been all of these months when I sat through the committee hearings and heard what we are doing.

I want to say with the Education and Labor Committee, the Nurse Training and Retention Act and the Student-to-School Nurse Ratio Improvement Act is in this bill, H.R. 3962. The Nurse Training and Retention Act will provide grants so we can have more new nurses, but to have more new nurses, we have to have those who are educated to teach those nurses. We have that in this bill, too.

I also want to say that for years I have been fighting with the insurance companies to make sure that children who are born with disfigurements on their face can have corrections so long term they won't have those scars, physically and mentally, and to help those families adjust to the child. In this bill, we will be able to say that the plastic surgeons can work on these children.

Think about a child who is born without an ear. The insurance companies say that is cosmetic. That is not cosmetic. The ear is actually part of the body so you can actually hear better. But the emotional scars that happen to the children that are born with these deformities, that is wrong.

If we can't take care of our children in this country, if we can't make sure our seniors on Medicare get the kind of care that they need—I will tell you, I just went through surgery. I went to get my prescriptions filled, and my pharmacist said to me, How lucky, you don't have to pay anymore for your prescriptions until January 1. Why? Because I have coverage, because I have health care from the Federal Government. We can do better, and we should.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Minnesota (Mr. KLINE) for 40 minutes.

Mr. KLINE of Minnesota. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, we have before us today more than 2,000 pages of legislative text that will give us public policy that costs more than $1 trillion and creates a huge morass of government bureaucracies. Over a hundred new offices, bureaus, commissions, and programs. Let's look briefly at just one of these new offices.

The Democrats empower a new super bureaucrat with unprecedented authority over personal health care decisions, the health choices commissioner, heading up the Orwellian health choices administration.

In the short time we have had since this legislation was made public, we have combed these pages—in the first part of these 2,000 pages—to see if we could get a picture of the responsibilities, authorities, and powers that were granted to this individual. As you can see, Madam Speaker, we actually had to go back to the supply store to get enough of these tabs.

This super bureaucrat, this health choices commissioner, it turns out will have powers to define, deny, deem, determine, assess, administer, and establish our health care benefits for all Americans.

It is no wonder that millions of Americans are afraid of a government takeover of our health care. How can they not fear such a thing? This is unprecedented, this amount of power granted to one bureaucrat. And, of course, there are other bureaucrats in this bill.

I don't believe that this bill should see the light of day. It certainly should not pass. It is a recipe for job losses. It is a clear power grab by Washington bureaucrats. It is a power grab. We ought to discard it altogether. Press the reset button, start over. We can do better. The American people deserve better. Let's vote ''no'' on this power grab by Washington bureaucrats.

I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey has 1½ minutes remaining.

Mr. ANDREWS. Madam Speaker, at this time I would like to yield to a gentleman who authored a very key provision about saving money through medical records technology, the gentleman from Oregon (Mr. WU) for 1½ minutes.

Mr. WU. Madam Speaker, I rise today in strong support of health insurance reform. In 20, 40, 60 years, this legislation will stand beside Social Security, the GI bill, and Medicare as a pillar of American health care and humane values. The bill creates a new health insurance exchange or marketplace to expand access and provide people with a menu of quality health insurance options so they can choose the plan that best meets their own needs.

The bill would create affordability credits to ensure that all Americans have more affordable health care coverage.

The bill will set a yearly limit on how much you can be charged for out-of-pocket expenses because no one should go broke because you get sick.

In short, what health insurance reform means for Americans is more security and stability. Americans should not have to wait any longer for these reforms. We have been waiting since Theodore Roosevelt. We have been waiting since Franklin Roosevelt. We have been waiting since Harry Truman. We have been waiting since Lyndon Johnson. We have been waiting since Jimmy Carter. We have been waiting since Bill Clinton. It is time to stop the waiting and it is time to act.

The SPEAKER pro tempore. The time of the gentleman from New Jersey has expired.

Mr. KLINE of Minnesota. Madam Speaker, I yield for the purpose of a unanimous consent request to the gentleman from California (Mr. LEWIS).

(Mr. LEWIS of California asked and was given permission to revise and extend his remarks.)

Mr. LEWIS of California. Madam Speaker, I rise to oppose H.R. 3962.

Madam Speaker, our health care system is the envy of much of the world. That does not mean it is perfect.

Major challenges such as pre-existing conditions and portability can be dealt with by breaking down barriers between states and through nationwide underwriting.

California-style liability reform provides a model to reduce the cost of defensive medicine and can significantly reduce the cost of health care.

Tax incentives can be used to encourage broader participation by families, without federal mandates.

The Speaker and her congressional advisors are committed to government-run health care. We can solve existing problems without adding a trillion dollars on the backs of average American taxpayers.

Vote "no" H.R. 3962. Help save us from single payer healthcare.

Mr. KLINE of Minnesota. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey (Mr. ANDREWS) is recognized for 40 minutes.

Mr. ANDREWS. Madam Speaker, at this time it is my honor to yield 4 minutes to a person who has spent a distinguished career in this House fighting for this day, who is one of the principal authors of this bill, the leader of our committee, the chairman of the Committee on Education and Labor, the gentleman from California (Mr. GEORGE MILLER).

Mr. GEORGE MILLER of California. Madam Speaker, I thank the gentleman so much for his contribution to this legislation, to the debate in this House, and to the role he has played in informing our Members and the public about this bill.

I want to begin by giving thanks, Madam Speaker, particularly on my committee, I want to thank the staff that have worked so terribly hard, Michele Varnhagen, Megan O'Reilly, Jody Calemine, Aaron Albright, Meredith Regine, and Rachel Racusen, who have all supported this tremendous team and the professional staff of the Committees on Ways and Means and Energy and Commerce, and certainly to my colleagues, Chairman RANGEL and Chairman WAXMAN, and to our subcommittee chairmen, Mr. ANDREWS, Mr. PALLONE and Mr. STARK. It has truly been an honor to have been involved in this debate and sit in the same room with the dean of our House, JOHN DINGELL, and to be able to craft this legislation. It is an honor I will remember the rest of my life, and I thank the Democratic leadership for giving us the space to bring President Obama's bill to this House so we can pass it and change America. And I want to thank Speaker PELOSI. Without her leadership, her tenacity and her passion, we would simply not be here today.

We are about to make history, and the reason we are about to make history is because many of us have so much confidence in the great things that America is capable of achieving. America has been challenged throughout its history to achieve great things on behalf of Americans, on behalf of the world community. We have risen to that challenge. But throughout that history, one challenge has eluded us: the challenge to come and to finally provide access to affordable health care for all of our citizens, for all Americans, to provide them the kind of security that they would know with this legislation, to provide them the understanding that never again will they live in fear that they will be without health care, for whatever circumstances take place in their lives.

And every Member in this Chamber on both sides of the aisle have encountered our constituents over our public careers as they have told us terrible stories, dramatic stories, painful stories, sad stories, about how their family has been crushed, or their friends or their neighbors that they care about or work with, by circumstances beyond their control. How, when one circumstance leads to another, how in America today when the layoff notice comes, you are also on notice that you will lose your insurance. Your world is turned upside down immediately. You struggle to find employment or retraining. You struggle to refigure your family's finances. And you know if your children are sick, they won't be able to go to the doctor—you won't be able to afford it. If your spouse is in the middle of treatment, that treatment can be curtailed, no matter what the illness, no matter how important the treatment is. It can go in a flash.

We cannot continue to ask American families to continue to live on that edge of uncertainty, of insecurity, of the possibility of fiscal ruin. A small event, because of the lack of health care, can explode into the life of a family, into the life of a community when it happens over and over and over again.

But this legislation says that's not going to happen again in our future. We are going to become the architects and the builders of a system that will provide care to these people, will provide services to these people, will provide security for these people so that these American families can go to work with confidence. They can buy a home with confidence. They can think about their kids' education with confidence, and know it will not be all wiped out in a flash because their insurance was canceled.

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

Mr. ANDREWS. I yield the gentleman an additional 1 minute.

Mr. GEORGE MILLER of California. That is what this legislation is about. We can talk about all of the internal merits and the back and forth. But at the end of the day, for the first time in our history, we deliver to all Americans the security that their family will have an opportunity to continue on a stable financial track and that they can make the kinds of plans that we want to make for our children, our grandchildren, that their neighbors might be able to make.

But in America today, because of the absence of this policy, because of the absence of a comprehensive health care bill that provides universal access, because of the failure of a bill that will help families that are struggling to meet the demand to pay the premiums, because of that failure, as The Wall Street Journal said, we pay a huge price in innovation because people know they will be penalized if they start a new business, if they take an idea and try to take it to fruition, if they switch jobs for a better opportunity maybe career-wise but that doesn't have insurance, if they want to go to work for a start-up where they can't provide insurance.

Let's give America for the first time health care security for their families, their friends, their kids, and their neighbors.

Madam Speaker, I rise in support of this historic legislation to fix our broken health insurance system and finally bring affordable health coverage to every American.

We are truly on the verge of making history.

Never before has the House or Senate approved a bill to guarantee every American access to affordable health care.

Never.

Not that we haven't tried.

The fight to reform this Nation's health care system has spanned nearly 100 years, across generations and many great leaders, from Teddy Roosevelt to Franklin Roosevelt to John F. Kennedy to President Clinton to my own personal hero, Ted Kennedy.

But time and again these efforts were stymied by special interests.

The need for reform is dire.

Hundreds of thousands of people are losing insurance each month.

At least 36 million Americans have no coverage at all—including nearly 50,000 people in my district in Northern California.

Over half of all personal bankruptcies are due to a medical incident.

Businesses are choking on bloated health care costs.

Innovation is being stifled. Our competitiveness is undermined.

But this year is different. This time is different.

The American people literally cannot afford to wait any longer, and today we will cast a history-making vote to guarantee all Americans access to quality, affordable health insurance.

We must not fail again.

An unprecedented effort by the House led us to this milestone.

Three committees and our diverse Caucus worked together in an extensive and coordinated fashion, with one purpose—to fulfill a decades-old and yet still urgent promise.

We engaged the public in one of the most transparent debates of federal legislation in history, including over 2,000 events across the U.S. since July alone.

The result is a bill that reflects what we have heard from workers and families, from small business owners and economists, from seniors and college students, from doctors and nurses.

The Affordable Health Care for America Act will directly meet the needs of Americans and the goals that President Obama set for reform:

It lowers costs for families and businesses,

Protects people's choices of doctors and health plans, reduces the deficit, and

Ensures access to quality, affordable health insurance for all Americans.

For the first time in U.S. history, all uninsured Americans will be able to purchase quality, affordable coverage through a new Health Insurance Exchange, where they will be able to choose from a menu of options: a public health insurance option or several private plans.

And for those that already have insurance, our bill will grant them the security of knowing that their coverage will always be there.

Never again will Americans worry about losing their health care if they change or lose their job.

Never again will someone be denied health care coverage because of a pre-existing condition.

Never again will a patient have to worry about their insurance company rescinding their policy when they need coverage the most.

Never again will a small business owner have to worry about unpredictable and unaffordable premiums.

Our bill, H.R. 3962, will end the many injustices that workers, families, and businesses face in today's system.

It will finally make health insurance work for consumers—not insurance CEOs.

Let me be specific about what our reforms will mean for the American people:

No more co-pays or deductibles for preventative care;

No more rates increases because of a pre-existing condition, gender, or occupation;

An annual cap on out-of-pocket expenses;

Guaranteed affordable dental, hearing and vision care for children;

Lower prescription drug costs for seniors;

Young people will be able to stay on their parents' insurance through their 27th birthday; and

A ban on lifetime caps on what insurance companies will pay, so patients will never again be one treatment away from medical bankruptcy.

As I mentioned earlier, this legislation meets our commitment to fiscal responsibility.

Every piece of this bill is fully paid for through a combination of revenue raised by placing a surcharge on the wealthiest Americans and savings generated by making Medicare and Medicaid more efficient.

These reforms will strengthen Medicare for seniors and shift our system's focus from quantity of health procedures to quality of care and producing healthier outcomes for patients.

The Congressional Budget Office reports that our bill will reduce the deficit by more than $100 billion over the next decade and slow the growth of health spending, leading 11 chief health care economists to declare our legislation "vital to the Nation's fiscal and economic future."

As with previous efforts to reform health care, this bill received an enormous amount of public scrutiny.

In the last few months, opponents of health reform have conjured up every falsehood imaginable about this bill in an effort to scare the American people and once again try to stymie reform.

But as I said, I believe that this year is different. Our legislation has been tested in public and the momentum continues to grow in support of the bill.

The American people have seen through the lies and distortions.

And they are not fooled by the hoax of an 11th hour Republican bill that is nothing more than a cruel rebuke to the needs of the American people.

Their bill would do nothing but maintain the status quo and guarantee insurance profits at the expense of tens of millions of hard working Americans.

The public understands the true meaning of our bill.

They know it will cover 96 percent of Americans.

They know that, under our bill, if they lose their job they will continue to have health coverage for their children, spouses and families.

They know that this bill means that if they have cancer, the insurance company can no longer pull the rug out from under them while they're in the middle of treatment.

They know that this bill will protect them, through any economic cycle.

Nearly 50 years ago, as he was fighting to expand health care benefits, President Kennedy said,

All of the great revolutionary movements of the Franklin Roosevelt Administration we now take for granted. But I refuse to see us live on the accomplishments of another generation. I refuse to see this country and all of us shrink from the struggles which are our responsibility in our times.

We must not shrink from the struggle for health reform, which is our responsibility in our time. This is our moment to revolutionize health care in this country.

We have arrived at this historic moment thanks to the hard work of so many people.

I would like to thank my good friends and colleagues, Chairman RANGEL and Chairman WAXMAN, and our three subcommittee chairs, ROB ANDREWS, FRANK PALLONE and PETE STARK, and especially DEAN DINGELL. We could not have had better teammates in this journey.

I would also like to thank the Democratic Leadership, our Speaker, Ms. PELOSI, the Majority Leader, Mr. HOYER, our Whip, Mr. CLYBURN, and all the members of leadership for the countless hours they spent working with the committee chairs to arrive at this point today.

And of course we could not have completed the work on this bill without the work of our incredibly talented staff, who worked long nights and weekends for months on end. They are the unsung heroes of this process, and I know all our colleagues join me in thanking them for their extraordinary work.

From my staff I would like to thank Mark Zuckerman, Alex Nock, Danny Weiss, Michele Varnhagen, Megan O'Reilly, Jody Calemine, Tico Almeida, Meredith Regine, James Schroll, Rachel Racusen, Aaron Albright, Amy Peake, Courtney Rochelle, and Mike Kruger.

Finally, I'd like to pay tribute to my mentor and friend, Sen. Edward M. Kennedy.

Health care was the cause of Ted's lifetime. Our effort would have been impossible had he not carried the torch of justice and equality for all those years.

I know I am not alone when I say that I sincerely wish Ted Kennedy could be with us today to see his dream of quality, affordable health care for all become a reality.

Madam Speaker, this is the most important bill I have ever worked on during my many years of service in Congress.

I could not be prouder to have helped to write this bill, to encourage each of my colleagues to support it, and to cast my vote in favor of the Affordable Health Care for America Act.

We stand at the doorstep of history.

Let us go in.

□ 1800

Mr. KLINE of Minnesota. Madam Speaker, at this time, I yield 3 minutes to the ranking member of the Health Subcommittee, certainly a member of the committee, the gentleman from Georgia (Dr. PRICE).

Mr. PRICE of Georgia. Madam Speaker, health care at its very core is a compassionate and a moral human endeavor. As a physician, I can tell you that I never saw a Democrat or a Republican disease. The medical decisions that each American makes for themselves and for their families are some of the most important and personal decisions ever made, and there are principles of health care that we should follow. Think about those principles of accessibility and affordability and quality and responsiveness and innovation and choices. Think about those principles. None of those principles are improved by the further intervention of the Federal Government, which is why we should adopt and concentrate on positive, patient-centered health care reform.

It is so very important that principles be in place that will ensure that patients and their families and their doctors are able to make those personal medical decisions unencumbered by a stifling and oppressive Federal Government. But sadly, this bill will not allow those independent decisions and is wrong in so many ways.

This bill, on page 94, will make it illegal for any American to obtain health care not approved by Washington. This bill, on page 301, will force Americans to purchase health coverage that Washington picks, not that you select for yourselves. This bill, on pages 297 and 313, places job-killing taxes on virtually every single business. This bill, on page 211, will force millions of Americans to lose their current personal private health coverage.

This bills comes with a price tag of $1.3 trillion, which will be borne by our children and our grandchildren. This bill, on page 520, slashes billions of dollars from Medicare that will necessitate health care rationing for seniors. And this bill, on page 733, empowers the Washington bureaucracy to deny lifesaving patient care if it costs too much.

This bill is not a health care bill. This bill is an affront on the morality of the provision of American health care.

As a physician, when patients and their families and their doctors are not allowed to independently decide what care should be provided, we lose more than our health care system; we lose our morality and we lose our freedom.

This bill, whether known or not, is an oppressive affront to every single American. The positive vote, the bipartisan vote on this bill is ''no.''

Mr. ANDREWS. Madam Speaker, I am pleased to yield to a Member who understands the immorality of 47 million uninsured. The gentleman from Michigan (Mr. KILDEE) is recognized for 1 minute.

Mr. KILDEE. I thank the gentleman.

Madam Speaker, I rise today in strong support of H.R. 3962, the Affordable Health Care for America Act.

Choices regarding health care are some of the most personal decisions we make. The ability to choose one's doctor and decide on a course of treatment with one's physician is an undeniable American right, and so is access to quality affordable health care.

Most of us can agree that our current health insurance system is broken. The cost of health insurance has skyrocketed in recent years, leaving many families struggling to afford coverage or forcing them to go without. Others are denied insurance due to preexisting conditions, saddling them with terrible medical debt when they need treatment.

These treatments, along with other factors, Madam Speaker, have led to nearly 50 million Americans without any health insurance; 71,000 live in my district.

I urge the passage of this bill.

Lack of adequate health coverage leads many people to wait until an emergency to seek medical treatment, turning what could have been a simple doctor's visit into a costly trip to the E.R. What many people do not realize is that when patients cannot pay their bills, the American taxpayer is charged for a portion of that cost. Medical providers also absorb some of the costs, forcing them to raise the prices of services and thereby increasing costs for everyone and driving up health insurance premiums. This problem will only get worse over time, and health care will continue to become more and more expensive.

The House health insurance reform legislation addresses this issue by increasing competition between insurers, thereby lowering costs. It also prevents insurers from denying or dropping coverage due to pre-existing conditions. By treating conditions earlier at a doctor's office, instead of at the emergency room, it will save money for the patient, the taxpayer and the medical providers, ultimately bringing down health care costs for everyone.

This is an issue that Congress has been tackling since the days of Harry Truman and even before and I am proud to stand with my colleagues in passing this long awaited bill.

Mr. KLINE of Minnesota. At this time, I am very pleased to yield 1 minute to the gentlelady from North Carolina, a former member of this committee and now a member of the Rules Committee, Dr. FOXX.

Ms. FOXX. I thank my colleague from Minnesota.

The people of America are struggling with 70 percent effective unemployment brought on by actions of this Democratically controlled government. And what do the Democrats want to do? Give us more government. They expect us to believe that more government control of our lives is good. More government control is not good.

We've been successful as a Nation because of our freedom. Taking away freedom will weaken us as a people and a country. The American people know that and have told us that. They're opposed to this bill.

Medicare, the kind of treatment they want us to have, denies treatment more than twice as often as most private insurance. That will be our future: rationed health care and destruction of freedom.

My colleagues should say no to the Pelosi-Obama freedom-killing, job-killing H.R. 3962.

Mr. ANDREWS. Madam Speaker, when people were about to be deprived the freedom to choose a public option, the Progressive Caucus stood up. The leader of the Progressive Caucus that led that effort will now be our next speaker.

The gentlewoman from California (Ms. WOOLSEY) is recognized for 2 minutes.

Ms. WOOLSEY. Thank you to Congressman ROB ANDREWS, who kept this clear and made it understandable for every single person in this country. Thank you, Congressman.

Well, let's put aside all the numbers and fuzzy terminology and let's talk about what this bill really means to average Americans.

Madam Speaker, I will never forget 40 years ago waking up in the middle of the night with a start night after night after night because I did not have health insurance for my three small children, and it was not anything that had to do with anything that we had caused. I would wonder what would happen, what if my children got ill or one of them was injured because of no health insurance? Well, this bill that we're talking about today, with it, our family would have been secure. We would have been much healthier because we would have known that we had health insurance.

So, Madam Speaker, let's take a family of two, two working parents, two children. With this bill, if one of the children gets sick, the parents won't have to worry about arguing with the health insurance company for treatment. If the mother gets breast cancer, the family won't have to worry that their health insurance company will cancel their coverage because it doesn't want to pay for her treatment. If one of the parents loses his or her job, and along with it the family's health insurance, they will be able to go into the health exchange and choose between private and public plans. If the family can't afford to pay the premiums, there will be affordability credits to help them.

That security would have meant a better life for me. It would have meant a better life for my children that year. We want to make sure that every child has that security.

Mr. KLINE of Minnesota. At this time, I am very pleased to yield 1

minute to a very important member of the committee, the gentleman from Wisconsin (Mr. PETRI).

(Mr. PETRI asked and was given permission to revise and extend his remarks.)

Mr. PETRI. I thank my colleague from Minnesota.

Madam Speaker, unemployment is 10.2 percent, the highest in 26 years, yet here we are being asked to vote on a bill which will radically alter and disrupt one-sixth of our economy, hit businesses with costly new regulations, ratchet up monstrous Medicaid mandates on the 50 States, raise taxes on job creators, impose skyrocketing insurance premiums on individuals and families, and destroy popular Medicare Advantage plans, all this while failing to bend the cost curve down and providing no real liability reform.

At a time of record deficits, this bill spends over $1 trillion to provide health insurance to less than 15 percent of Americans. To pay for this budgetary train wreck, it imposes $730 billion in new taxes and relies on a series of budget gimmicks in a slippery attempt to claim it won't contribute to our deficit tsunami.

This legislation will bring about a radical intrusion of government into every sector of health care. It puts bureaucrats between patients and their doctors. It doesn't make sense, isn't very smart.

Let's not pass this monstrosity.

I certainly agree that it is time to fix the health care system in the United States so that all Americans have access to quality, affordable health care. In order to achieve this goal, I strongly believe that any bill that is approved by Congress must institute reforms that will address the rising cost of health care.

The majority of Americans have some kind of health insurance they are generally satisfied with. What they really care about is rising costs. Spending on health care services already accounts for about 17 percent of gross domestic product (GDP)—an expected total of about $2.6 trillion in 2009. Health care inflation has outpaced general inflation by approximately 2.5 percent a year. Government spending on health care continues to grow exponentially and without action, spending on Medicare and Medicaid will rise from 4 percent to 19 percent of GDP in 2082.

However, the bill we are considering today takes us in the entirely wrong direction by instituting reforms that will increase health care spending while doing little to bend the cost curve. This legislation is best categorized as an entitlement expansion rather than health care reform. At a time of record deficits, H.R. 3962 spends $1.055 trillion to provide health insurance to less than 15 percent of Americans. Furthermore, almost 15 million of these individuals will receive insurance coverage by expanding the eligibility of Medicaid. This results in the largest expansion of Medicaid since its inception almost forty years ago. In fact, according to the Congressional Budget Office, the bill will increase the federal budgetary commitment to health care by $598 billion in the first ten years alone!

To pay for this budgetary train wreck, H.R. 3962 imposes $729.5 billion in new taxes on small businesses, individuals who cannot afford health insurance, and employers who cannot afford to provide coverage that meets new insurance standards. In Wisconsin, the "surtax" that provides the largest source of funding for the bill will hit 11,900 small businesses—at a time when unemployment is hovering around nine percent. Individuals who are dependent on medical equipment such as wheelchairs and hearing aids will also face increased costs because of additional taxes in this bill—at a time when many families are struggling to pay their monthly bills.

Furthermore, H.R. 3962 relies on a series of budget gimmicks to make it appear that the bill would not increase the federal deficit. First, the legislation fails to account for this year's projected 21 percent cut to Medicare physician reimbursements, which if allowed to go through would severely threaten seniors' access to physicians. However, preventing this and future cuts will cost over $200 billion. Instead of making this fix in H.R. 3962 and accounting for its cost, the Democratic House leadership introduced it as a stand-alone bill without offsets—despite the fact that the Senate already rejected this approach. H.R. 3962 also proposes over $400 billion in cuts to Medicare. However, as many acknowledge, Congress has a history of reversing itself on unpopular cuts to Medicare, so it is very questionable as to whether these savings will be realized. The legislation also authorizes a new long-term care program which is funded through a voluntary payroll tax. H.R. 3962 uses these pay roll contributions for other spending priorities in the bill, instead of the benefits that will eventually have to be paid out under the new program. Even the Democratic Chairman of the Senate Budget Committee, KENT CONRAD, called the inclusion of this program a "Ponzi scheme." Finally, only 7/10th of a percent of new spending occurs in the first three years, while most of the tax increases begin at enactment, representing a debt and "tax" time bomb.

Besides increasing taxes and adding to the exploding deficit, this legislation represents a radical intrusion of government into every sector of health care. H.R. 3962 gives the government unprecedented authority over the regulation of health insurance. The top-down bureaucratic model of mandating extensive cost sharing and coverage requirements will do very little to ensure high quality care and will certainly lead to increased costs.

We should be doing the exact opposite and giving consumers, rather than government bureaucrats or insurance companies, more responsibility for decisions regarding their health care. This bill does nothing to incentivize consumer driven health plans which encourage individuals to take care of themselves, save for future medical expenses and comparison shop to find the best health care at the most reasonable cost. Most importantly, consumer driven plans put into motion the incentive structure throughout the health care delivery system that will slow the rising cost of health care.

In fact, many of the reforms and new mandates in H.R. 3962 will actually raise the cost of health insurance for those that are now covered. Multiple studies have demonstrated that younger and healthier Americans could see their health care premiums triple, and a family of four could see its health care premiums more than double. While H.R. 3962 mandates that all citizens purchase "acceptable coverage," in reality many young and healthy individuals may find it more economical to forego coverage and pay the penalty which is less expensive than the cost of buying health insurance. Should younger and healthy people forego coverage, premiums for everyone else will increase. In fact, because of the bill's ban on insurance companies discriminating against pre-existing conditions, younger healthier people will have even more of an incentive to wait until they are sick to purchase health insurance.

The legislation also breaks the President's promise that if you like your health insurance you will be able to keep it. The legislation makes significant cuts to Medicare Advantage Plans which will surely eliminate or reduce benefits to the 216,000 beneficiaries in Wisconsin.

Furthermore, the legislation places an 8 percent tax on businesses that don't offer acceptable coverage, as defined by federal bureaucrats. According to the Galen Institute, a nonprofit think tank, "data from a 2009 Kaiser Family Foundation survey suggest that at least 30 percent of firms with fewer than 200 employees that now offer insurance would fail the test for family coverage, and about 20 percent would fail individual coverage." However, instead of complying with the new mandates, many employers will likely stop offering health insurance to their employees because the 8 percent payroll tax penalty is less than the cost to provide coverage. Furthermore, the extensive new federal record keeping and audit requirements provide further incentives to stop offering coverage. In fact, a study by Blue Cross and Blue Shield demonstrated that "complying with the new actuarial standards in the bill would increase average costs by 17 percent for individuals and almost 10 percent for small employers."

Over 80 percent of the money spent on health care in the United States today is spent on the delivery of health care. Yet, what we see in today's bill is just "more of the same" in the delivery of care instead of making fundamental changes to reward high quality, low cost care. The bill authorizes hundreds of Medicare pilot programs to test different ways to pay doctors and hospitals for quality of care. But once again, these pilots are governed from the top-down and typically take years to initiate and rarely result in reforms applied throughout the system. Instead, we should be supporting efforts that are coming out of both the states and multi-collaborative projects between networks of hospitals, businesses and physicians. Wisconsin hospitals such as ThedaCare, Marshfield Clinic, Gunderson Lutheran, and Aurora Health Care have long been engaged in transforming the delivery of care to get rid of the inefficiencies and provide low cost, high quality care. We should be supporting these reforms from the bottom-up, instead of repeating the work that has already been done.

And finally, I have grave concerns that the legislation will allow for government funding of abortions and threaten current conscience protections for health care providers. I strongly believe that the Hyde Amendment should be codified in this legislation.

Today, I will vote in support of Congressman BOEHNER's substitute amendment which is a good step forward in lowering health care premiums for families and small businesses,

increasing access to affordable high quality care, and promoting healthier life styles—without adding to the deficit.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to heed the gavel.

Mr. ANDREWS. Madam Speaker, I yield myself 30 seconds before the next introduction.

There is a credibility issue here. The minority says the bill doesn't have enough prevention, but the American Cancer Society supports the bill. The minority says it destroys the doctor-patient relationship, but the American Medical Association supports the bill. The minority says it's bad for America's seniors and for Medicare, but the AARP supports the bill. I think there is a credibility issue, and it doesn't work for the minority.

At this time, I would be happy to yield 1¼ minutes to the gentleman from Pennsylvania (Mr. SESTAK).

Mr. SESTAK. Madam Speaker, a little shy of 3 years ago, I came to this Congress to pay back a debt. After three decades in the U.S. military, my young 4-year-old was struck with the same brain tumor Senator Ed Kennedy had. Because of the wonderful health care plan that this Congress provides our families in the military, she was given a chance.

I was taken in the U.S. military by how and why we do that. It's not because we're generous. It's because we reap great dividends for this Nation. This Congress sent me off for 11½ months to a war, and while I was gone, my daughter and my wife were taken care of and my mind was on the mission. In the military, we reap the benefit of healthy, focused warriors.

I am taken with this bill. It gives us healthy, productive workers. It actually combines, in my mind, the best of America's character—rugged individualism allied with the common enterprise of this Nation. It gives us the quality of life that in the military reaps such great dividends. This bill, to me, is no different, and it's time.

Mr. KLINE of Minnesota. Madam Speaker, at this time, I yield 2 minutes to the ranking member of the Armed Services Committee and the former ranking member of the Education and Labor Committee, the gentleman from California (Mr. MCKEON).

Mr. MCKEON. Madam Speaker, I thank the ranking member for yielding.

It's been said that Abraham Lincoln said, ''You cannot bring about prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the wage earner by pulling down the wage payer. You cannot further the brotherhood of man by encouraging class hatred. You cannot help the poor by destroying the rich. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away man's initiative and independence. You cannot help men permanently by doing for them what they could and should do for themselves.'' Madam Speaker, what we're doing here violates all of these principles that Abraham Lincoln spoke so eloquently about.

I rise today in strong opposition to this Pelosi bill of over 2,000 pages. At a time when we are suffering the highest unemployment in this country since 1983, the American people can't afford these massive new spending increases, and I refuse to pass this great burden on to my children and grandchildren.

I offered two amendments to try to improve this bill: one to require Members of Congress to enroll in the public option like we're going to require all of you to do, and one that said that illegal immigrants would not receive new benefits under this new bill; commonsense provisions that were voted down by the Democrats in the Rules Committee. In fact, Democrats voted down every single Republican amendment but one. How is that for bipartisanship?

This legislation increases taxes, kills jobs, and costs over $1 trillion in money we don't have. The Republican plan will cut costs through tort reform, negotiating across State lines, and through purchasing power.

Support the Republican alternative and oppose the Pelosi plan. This is an absolute disaster.

□ 1815

Mr. ANDREWS. Madam Speaker, before I yield to my next speaker, I yield myself 30 seconds.

With all due respect, what is an absolute disaster are the repeated misrepresentations of certain things that are in this bill, and we just heard one. No one is forced to join the public option. No one. It is not in the bill; and I would, frankly, invite the minority to show us where it is.

Secondly, Members of Congress are positioned exactly the way everyone else is with the public option. When and if the time comes that the Federal Government is a participating employer in the exchange, we can either choose the public option or not. The House deserves an accurate record.

I yield 1½ minutes to a woman who stood for fiscal soundness not only here in Washington but in New Hampshire for her State budget, the gentlewoman from New Hampshire, CAROL SHEA-PORTER.

Ms. SHEA-PORTER. Madam Speaker, I rise today to support the Affordable Health Care for America Act. This is a historic moment for our Nation.

In my district, this bill will provide coverage for 37,000 uninsured residents; 128,000 households will qualify for credits to help them afford the coverage of their choice. We will invest more in community health centers. We make Medicare stronger, which is why AARP has endorsed this bill. We start to close the Medicare part D doughnut hole in 2010, and it will be completely closed by 2019. We will provide a 50 percent discount for name-brand drugs for those in the doughnut hole, and we eliminate copayments for preventative care.

Today, we make history for our seniors, for our children, for the middle class—for all Americans. Today, we vote for an America where discrimination based on preexisting conditions is a thing of the past. Today, we vote for an America where getting sick doesn't mean losing your home. Today, after decades of debate, we finally vote for a healthier America.

Mr. KLINE of Minnesota. Madam Speaker, before I yield to the gentlewoman from Washington, I yield for a unanimous consent request to the gentleman from Kentucky (Mr. ROGERS).

(Mr. ROGERS of Kentucky asked and was given permission to revise and extend his remarks.)

Mr. ROGERS of Kentucky. Madam Speaker, I rise in opposition to this freedom-taking bill.

We can all agree that health care costs are too high and that we need to open up access for more Americans. That being said, we need to pass a bill that actually cuts costs and increases access rather than a government-run takeover of health care. I cannot support Speaker PELOSI's monstrosity of a bill because it puts a Washington bureaucrat between individuals and their doctor, it adds to our enormous debt in Washington, and, even more frightening, it will limit health care availability in rural regions like southern and eastern Kentucky.

In these challenging economic times, with double digit unemployment, out of control government spending sprees, and bailout after bailout, we should not pass a bill that will kill jobs and raise taxes. Speaker PELOSI's government-run health care bill not only imposes new penalties and taxes on small businesses, it raises taxes on already struggling individuals and families. Whether someone wants health insurance or not, they'll be forced to purchase it, and the federal government will garnish wages or send them to jail if they don't comply. Even more troubling, the more vulnerable and ailing one is, the more they'll pay, as this bill imposes new taxes on critical medical supplies, like wheelchairs, oxygen tanks, hospital beds, and prosthetic limbs. As if that wasn't enough, the bill opens the floodgates of taxpayer money for illegal immigrants to abuse the system and obtain free government health insurance—all on the backs of law-abiding Americans. Lastly, I am scared for our seniors as this bill makes devastating cuts to the Medicare program to the tune of $500 billion, and puts the popular Medicare Advantage program on life support, virtually eliminating its existence.

I support the Republican alternative health care bill that focuses on lowering health care premiums for families and small businesses, increases access to affordable high-quality health care, and promotes healthier lifestyles without adding to Washington's crushing debt. The plan I support guarantees access to affordable care for those with pre-existing conditions, ends junk lawsuits against our doctors, allows small businesses to band together to purchase insurance for their employees and allows individuals to shop for insurance across state lines. Simple and less costly initiatives such as these will lower insurance premiums by at least 10 percent, and provide health insurance to millions more Americans.

This bill reflects a fundamental and drastic change in our way of life, and is the largest government intrusion into the private lives of our citizens ever. I, for one, am truly frightened by the potential consequences.

Mr. KLINE of Minnesota. I am now pleased, Madam Speaker, to yield 2 minutes to a member of the committee, the ranking member on a subcommittee, the gentlewoman from Washington, CATHY MCMORRIS RODGERS.

Mrs. MCMORRIS RODGERS. I thank the gentleman for yielding.

Madam Speaker, we just need to slow down. The American public has made it clear that they want the right health care reform bill enacted, not just any bill.

Look at the stimulus bill that was rushed through Congress. Look at what has happened. They said, Oh, unemployment won't go over 8 percent. We are now at 10.2 percent. We have lost 3 million jobs, and we have a $1.4 trillion deficit.

Like my mom used to say, You rush, you make mistakes.

This health care reform bill will be no different. It spends $1.3 trillion. It taxes employers $750 billion, many of whom are small business owners, at the very time that we need these small business owners to be creating jobs. We need jobs. Isn't it interesting that even the administration's own economic adviser has estimated that this bill will cost America an additional 5.5 million jobs.

Other reforms in the bill all but eliminate Medicare Advantage, hurting 20,000 seniors in eastern Washington and millions across the country. For rural communities, the bill calls on the Institute of Medicine to study payment disparities in rural regions. So we are spending $1.5 trillion, and the only relief we get is another study? My list of concerns goes on and on.

The Republicans have a better way, one that lowers premiums for families by as much as 10 percent; one that saves billions in medical liability reform, allowing people to purchase health insurance across State lines; one that continues the continuity and coverage; and it's a solution that doesn't indebt our children and our grandchildren.

Madam Speaker, just this week, thousands of people stood on the Capitol steps. They called on Congress to oppose this legislation. I urge us to heed their warning. Vote ''no.'' Let's slow down the process, and let's get the right kind of reform, not just any kind of reform.

Mr. ANDREWS. Madam Speaker, I yield myself 15 seconds.

The gentlewoman just quoted an unnamed phantom Obama administration adviser. Christina Romer, the CEA chairperson for the Obama administration, says this bill will increase the GDP between 1–2 percent and will add several million jobs.

I am pleased to yield 1½ minutes to a strong voice for working families in this country, the gentleman from Illinois (Mr. HARE).

Mr. HARE. Thank you, Congressman ANDREWS.

Madam Speaker, when I was growing up as a young boy, my parents lost their home. My father was ill. He couldn't make the payments. I remember coming home the day of my older sister's wedding to see a process server with a notice to evict and 30 days to leave.

Two days before my father died, I sat by his bed, and he told me, There are two promises I want you to make to me: take care of the girls and your mother, and no matter what you do, please see that this will not happen to another family.

Tonight, in a few hours, I will have the opportunity to keep that promise to my dad and to the tens of thousands of other people who have lost their homes and everything they had simply because they were sick. All the fearmongering. All the misstatements of facts and figures. Health care in this country, my friends and fellow citizens, is a right. It is not a privilege.

So, tonight, for my father and for the people who came after him, I will stand proud for this bill no matter the amount of shouting, of tearing this down and of calling the bill whatever you want to call it. I call it getting people exactly what this country promises them: life, liberty, and the pursuit of happiness.

Mr. KLINE of Minnesota. Madam Speaker, I am pleased to yield 1 minute to a member of the committee, the gentleman from Michigan (Mr. HOEKSTRA).

Mr. HOEKSTRA. I thank my colleague for yielding.

Madam Speaker, today, I met Theresa. Theresa had a sign that read: I love my country. On the other side, it read: My future. Her brother, Xavier, had a sign that read: Give me liberty, not debt.

If we pass Pelosi health care tonight, tomorrow morning, we will still all love our country; but we will have jeopardized Theresa's future. A bailout, a stimulus, cap-and-trade, and Pelosi health care have jeopardized her future. For Xavier, we will have given him debt: another $1.2 trillion on top of the $1.4 trillion we gave him last year.

I will vote ''no'' because I believe that that's the vote that says: I love my country. I will vote ''no'' because I believe that that is the vote that preserves our future. I will vote ''no'' because I know that that will preserve Xavier's liberty and not give him more debt.

With that, I urge my colleagues to vote ''no'' on this bill.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 1½ minutes to a member who fought tirelessly for equality in Medicare reimbursement for the State of Iowa, the gentleman from Iowa (Mr. LOEBSACK).

Mr. LOEBSACK. Thank you, Mr. ANDREWS.

Madam Speaker, I am proud to be a part of this effort to improve health care in America, and I will support the bill before us because I have heard from countless Iowans about the desperate need to change the current system, and I believe this legislation before us today will provide true and comprehensive reform.

However, since coming to Congress, I have told just about everyone I could and everyone who would listen to me that comprehensive reform could not be achieved without addressing geographic disparities in the Medicare payment system. Many other Members agreed, and we formed the Quality Care Coalition, and we brought about that change.

There is much needed language in this bill to fix a broken Medicare payment system. By focusing now on the quality of services provided to patients instead of the quantity of services, this provision will provide a significant cost savings to Medicare, and it will benefit patients in Iowa and all across America.

In particular, I want to thank my leadership; my chairman on the committee, GEORGE MILLER; my friend ROB ANDREWS; Chairman WAXMAN; and Chairman RANGEL for their work on this issue.

I urge everyone to vote for this bill before us.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the committee, the gentleman from South Carolina (Mr. WILSON).

Mr. WILSON of South Carolina. Madam Speaker, America's leading voice for small business, the National Federation of Independent Business, the NFIB, opposes H.R. 3962, the Pelosi takeover bill. The NFIB has sounded the alarm about the employer mandate, payroll tax penalty and unnecessary paperwork mandate crippling small businesses.

The opposition letter from the NFIB warns that the Pelosi takeover includes multiple mandates. Economic research shows mandates are ultimately borne by the worker through job loss and lower wages. The NFIB also warns how the payroll tax penalty is a tax on jobs and job creation. Additionally, the unnecessary paperwork mandate will place a new paperwork burden on all small businesses at a time when they are struggling to stay afloat. The NFIB has estimated the takeover effort will kill 1.6 million jobs at a time of record unemployment.

We should support health insurance reform, not a government takeover.

NOVEMBER 5, 2009.

LETTER TO HOUSE OPPOSING H.R. 3962

DEAR REPRESENTATIVE: On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business advocacy group, I am writing in opposition to the Affordable Health Care for America Act (H.R. 3962). The Affordable Health Care for America Act does not reflect the access or affordability needs of NFIB's small businesses, and a vote against H.R. 3962 will be considered an NFIB Key Vote for the 111th Congress.

NFIB has been a constructive participant in the healthcare debate and has spent more than a decade voicing our need for reform. With healthcare costs ranking as the No. 1 issue facing small business, our employers must carefully weigh the potential benefits of reform against the new costs imposed on business owners in the legislation. NFIB members have identified specific areas in H.R. 3962 that will raise those costs:

Employer Mandate: H.R. 3962 includes an employer mandate that will require employers to pay for healthcare for full-time and part-time employees. An employer mandate does not address the No. 1 issue facing small businesses: unsustainable costs. This mandate affects those who do not offer coverage today as well as those who already do provide insurance, but aren't making contributions at contribution levels outlined in the bill (72.5% for individual plans and 65% for family plans). Rather than help, this will penalize employers already offering healthcare and force them to make hard choices about how to afford the new government requirements. Economic research has shown time and again that mandates such as these are a ''one-two punch'' where the cost is first borne by the employer, but is ultimately borne by the employee—through job loss and lower wages.

Payroll Tax Penalty: A payroll tax penalty is a tax on jobs and job creation because they tax labor. The legislation requires that all employers with a payroll of $500,000 or more pay a payroll tax of up to 8 percent if they do not provide ''qualified'' health insurance to their employees. No matter how profitable or unprofitable a business might be, they are forced to pay this tax. In addition, because the exemption thresholds in H.R. 3962 are not indexed for inflation, the exemption will become a healthcare equivalent of the alternative minimum tax, hitting more and more employers until there is no one exempted at all.

Paperwork Mandate: H.R. 3962 places a new tax-compliance paperwork burden on all small businesses. The ''corporate reporting'' provision is an expansion on reporting requirements (for transactions of more than $600), which increases the cost of operating a small business and diverts resources away from growing and creating jobs.

Big Benefit Package and More Mandates: Small employers need a guarantee that plans offered in an exchange will be less costly, not more expensive, than what they are paying today. Today, small businesses pay an average of 18 percent more for their healthcare, leaving them continuously searching for more affordable choices.

H.R. 3962 gives a political board the power to define ''coverage'' and will determine whether an employer plan is ''acceptable.'' However, the bill does nothing to ensure that the new plans will be less costly than what small employers are paying today. In some cases, the legislation will also require some small employers to cover benefits that are not currently mandated under federal law.

Takes Away Small Business Solutions: Small employers need more, not fewer, affordable health insurance options. However, the prohibition of HSA, FSA and MSA funds to purchase over-the-counter medications, along with the $2,500 limit on FSA contributions, threatens to further limit the ever-shrinking options employers have to provide meaningful healthcare to their employees.

Public Option: A government-run plan cannot compete fairly with the private market, and threatens to destroy the marketplace, further limiting choices. We believe that with proper reforms the private market can be held accountable to provide greater competition and lower-cost solutions where insurers compete based on their ability to manage, rather than shed risk. Instead, the excessively prescriptive insurance reforms in H.R. 3962 will drive up costs.

Surtax: Seventy-five (75) percent of small businesses are structured as pass through entities and pay their business taxes at the individual level. More than one-third of small businesses employing 20 to 250 employees could face the tax. Finally, since the tax is not indexed for inflation, the effect of the tax will creep downward, making more and more businesses vulnerable to a tax increase.

Poorly-Structured Tax Credit: There are two reasons the credit in H.R. 3962 is of limited value. First, the availability of the credit is too short. A credit that is only available for two years means that every small business owner that claims the credit will see a large spike in their out-of-pocket costs for health care in year three. Second, the wage limits are too restrictive. Phasing the credit out based on average wages of $20,000 or less severely reduces the amount of a tax credit available for most small businesses.

NFIB will continue to advocate for reform because, as both democratic and republican lawmakers have said, the status quo is not acceptable. Our small business owners agree, but reform must make the problem better, not worse. Because H.R. 3962 will not lower healthcare costs and threatens our economic recovery, NFIB will consider a NO vote a vote in support of small business. This will be an NFIB KEY VOTE FOR THE 111TH CONGRESS.

Sincerely,

SUSAN ECKERLY,
Senior Vice President,
Federal Public Policy.

Mr. ANDREWS. Madam Speaker, I yield 2 minutes to a gentlewoman who authored a provision to expand small business opportunities for affordable health insurance, the gentlewoman from Nevada (Ms. TITUS).

Ms. TITUS. Thank you, Mr. ANDREWS.

Madam Speaker, for more than 6 months, I've discussed the need for health care reform with my constituents; and time and again I've heard from small business owners who are struggling to afford health care coverage.

Over the last decade, the average health insurance premium has more than doubled for Nevada's small businesses. Without comprehensive reform, Nevada's small business health premiums are projected to again double over the next decade. In this year alone, small businesses across the country are being hit with a 15 percent average increase in premiums. It is clear that the status quo is unacceptable and unsustainable.

I had concerns about earlier versions of this bill, but I am pleased that H.R. 3962 before us today is significantly improved and takes important steps to help make health insurance more affordable.

I worked to raise the income level at which people are assessed a health care surcharge. The new threshold is significantly higher, up from $350,000 for couples to $1 million. This means that 98.8 percent of all small businesses will be exempt from paying any surcharge.

The bill also now exempts small businesses with payrolls below $500,000 from the employer mandate. That means that 86 percent of all employers are exempt, and many small businesses which choose to offer insurance to their employees will be eligible for a tax credit to help offset those costs.

I am especially proud that the provision I championed, which was to expand the health insurance exchange so that more businesses could participate, was included and strengthened in this bill. This will ensure that small businesses have additional options for purchasing health insurance at a lower cost.

All of these improvements combined will strengthen small businesses so they will be critical engines of growth in our communities. It is time small businesses knew who really stood up for them and cared about them and their employees.

I urge my colleagues to support this bill and to stand up for small business.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the committee, the gentlewoman from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. I thank the gentleman for yielding.

Madam Speaker, I rise in strong opposition to this $1.3 trillion government takeover of health care.

Time and again, the President promised the American people that, if they like the health insurance they have, they can keep it. So I introduced an amendment in the Education Committee that said what he said: if you like the health insurance you have, you can keep it.

The Democrats defeated this amendment with a unanimous vote.

This bill does not keep the President's promise. Instead, it would allow a group of unelected government bureaucrats to determine if the health insurance you have is up to government standards. If they say it's not and if you don't buy what they say you should buy, you will be fined. If you don't pay the fine, it's jail time.

I urge my colleagues to defeat the bill and to, instead, vote for the GOP alternative. Not only does it expand access to those who lack it and not only does it lower costs for everyone, but it cuts the deficit, preserves the doctor-patient relationship, and ensures that you can keep the coverage you have.

□ 1830

Mr. ANDREWS. Madam Speaker, a number of great and visionary men have stood at the podium where you stand now as Speaker of the House. Many of them tried to achieve significant health care reform; each of them failed. A lot of strong visionary men failed, so we will succeed with a strong, visionary woman.

It is my privilege to yield 1 minute to the Speaker of the House of Representatives, Congresswoman NANCY PELOSI.

Ms. PELOSI. I thank the gentleman for yielding, for his kind remarks and for his tremendous leadership on bringing this legislation to the floor. Thank you, Congressman ROB ANDREWS.

Madam Speaker, today as we all know is an historic moment for our Nation and for America's families. For nearly a century, leaders of every party and political philosophy have, as far back as Teddy Roosevelt, called for health care for the American people.

For generations, the American people have called for affordable, quality health care for their families. Today, the call will be answered. Today, we will pass the Affordable Health Care for America Act.

This legislation is founded on key principles for a healthier America: innovation, competition and prevention. It improves quality, lowers cost, expands coverage to 36 million more people, and retains choices.

Our innovation began in the recovery package in January with $19 billion for health IT, the first step in lowering cost and improving quality, and $8 billion in investments for biomedical research. This legislation will mean affordability for the middle class, security for our seniors and honors our responsibility to our children, adding not one dime to the deficit.

For all Americans, this legislation makes a big difference: no discrimination for preexisting medical conditions; no dropped coverage if you are sick; no copays for preventive care. There is a cap on what you pay in, but there is no cap on the benefit that you receive.

It works for seniors, closing the doughnut hole, offering better primary care and strengthening Medicare for years to come. It works for women, preventing insurance companies from charging women more than men for the same coverage. No longer will being a woman be a preexisting medical condition.

It works for young people, offers affordable choices and copays for preventive care to stop problems before they start, and allows young people to stay on their parents' insurance until their 27th birthday. It works for small business owners, providing access to affordable group rates and creating a tax credit to help them insure their employees. It works for consumers, keeping insurance companies honest and encouraging competition with a public option.

This legislation puts you and your doctor in charge. No longer will the insurance companies come between you and your doctor.

President Obama has said that health care reform is entitlement reform, and this legislation proves that point. It is fiscally sound, it is paid for, and it reduces the deficit by tens of billions of dollars over the next 10 years.

This legislation is the result of extensive deliberation here in the Congress, where we have held more than 100 hearings and is the product of extensive input from the American people. Members of Congress have held over 3,000 town meetings. It has resulted in a better bill than H.R. 3200. However good or excellent that was, this bill is a better one with significant differences, and my colleagues have pointed them out, as did Congresswoman DINA TITUS, who just spoke before me at the podium.

We are brought to this historic moment in our Nation for our families because of the work of our chairmen: Chairman HENRY WAXMAN of the Energy and Commerce Committee, Chairman CHARLIE RANGEL of the Ways and Means Committee, Chairman GEORGE MILLER of the Education and Labor Committee, and Chairwoman LOUISE SLAUGHTER of the Rules Committee. I thank all of those committees, including the Rules Committee, for being in so late so that we could have this legislation on the floor today and for their ongoing service to the Congress.

More than 300 groups representing tens of millions of Americans have expressed their support for the bill: the AARP, American Medical Association, the American Nurses Association; the list of medical groups goes on and on. The American Cancer Society Cancer Action Network, American Heart Association, American Diabetes Association. And I am particularly proud the Consumers Union has endorsed the legislation. My colleagues, this morning we were part of history, and we are this evening as well.

But a particularly poignant moment occurred when Chairman DINGELL took the Chair to preside over the debate, the beginning of the debate for health care. When he was a young man as a Member of Congress, he gaveled Medicare into law. It had been, as one of our colleagues said, in his DNA, this pursuit of health care for all Americans. His father had introduced the bill over and over again when he was in Congress and, as his successor, he continued that great legacy. Today he will see a lifelong dream of generations in his family come true as we begin the process of making this a reality.

It's impossible to talk about health care reform in America without talking about Senator Edward Kennedy. His leadership and his contribution to this debate is boundless. Health insurance reform was the cause of his life. He called it ''the great unfinished business of our society.'' On this issue he said what is at stake ''is the character of our country.'' When the President came to address the joint session, he quoted those comments by Senator Kennedy from a letter that the Senator had sent to him. What the Senator also said in the letter that was sent to President Obama before he died was this:

''I entered public life with a young President who inspired a generation and the world. It gives me great hope that as I leave, another young President inspires another generation and, once more on America's behalf, inspires the entire world.''

He acknowledged President Obama's ''unwavering commitment and understanding that health care is a decisive issue for our future prosperity.''

President Obama's leadership gives our Nation hope. Today, with this legislation, we will give them health. President Obama has said, ''We will measure our success in the progress that is made by America's working families.''

Today, with the passage of the Affordable Health Care for America Act, we will make history. We will also make progress for America's working families.

I urge my colleagues to support this important legislation.

Mr. KLINE of Minnesota. Madam Speaker, at this time I am pleased to yield 1 minute to someone who tells me that he is, in fact, very proud he doesn't have a section in this bill, a member of the committee, the gentleman from Indiana (Mr. SOUDER).

Mr. SOUDER. This is indeed a historic day. It's a crossroads in America. What you just heard from our distinguished Speaker was we, the government, will do this. We, the government, will do that. We, the government, will do this. We, the government, will do that. Instead of having the private sector do this, instead of having competition, instead of having capitalism do this, we, the government, will fix everything. We, the government, will provide everything.

We are in an economic crisis in this country. Just yesterday, for the first time, an over 10 percent unemployment. In my eight counties, over half are over 15 percent unemployment.

So what are we doing today? Taxing small business, the number one producer of jobs, adding regulations to those businesses, adding expenses to those businesses, taxing medical technology, which will reduce R&D, reduce jobs, reduce quality of health care.

What are we doing today? We are not going to require identification for illegal immigrants. We are going to hope that they self-report. With 1,990 pages of ignoring the voices of American people, you get higher taxes, fewer jobs, an unconstitutional takeover of 17 percent of our economy, a trillion dollars of debt, and free health care for the illegals who took your jobs.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 2 minutes to the gentleman who made sure that the ban on discrimination based on preexisting conditions will take effect as soon as this bill does, the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Madam Speaker, 45 percent of Americans suffer from some form of chronic disease, leaving them exposed to preexisting condition discrimination. The Commonwealth Fund found that 12.6 million non-elderly adults were, in fact, discriminated against by insurance companies because of preexisting conditions in the last 3 years.

This health care reform bill will abolish the barbaric discriminatory practice of denying insurance and charging more for insurance to Americans based on medical underwriting. Like Jim Crow laws, like separate but equal laws, like laws denying women

the right to vote or own property, the practice of denying coverage because of a person's internal biology, high blood pressure, diabetes or cancer will be forever abolished.

Section 211 of this bill ends this practice permanently in 2013; and section 106, which I wrote with Mr. ANDREWS' help, immediately provides relief by amending existing law to shorten the look-back period for group health plans from 6 months to 30 days and reduces the exclusion of coverage for preexisting conditions from 18 months to 90 days.

This balanced, well-thought-out reform of the Health Insurance Portability and Accountability Act of 1996 will provide tangible, real change for Americans terrified of losing their coverage because of a layoff or a job change.

What does the Republican plan do? Does it adopt section 106 or 211? No. On page 145 of the Republican bill, they call for—are you ready—a GAO study of the issue of preexisting conditions. The time for delay and dilatory studies is over. It is time to act.

As U.S. President Abraham Lincoln once said, it is time to make a more perfect union, and pass the Affordable Health Care for America Act.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1½ minutes to a distinguished member of the committee, the gentleman from Delaware (Mr. CASTLE).

Mr. CASTLE. Mr. Speaker, I rise in opposition to the legislation but in strong belief that the vast majority of us in Congress are committed to reducing the skyrocketing costs of health care today and expanding access to insurance coverage for those in need.

Additionally, I am certain that if we focused on the on the many shared bipartisan goals, we could pass a health reform package that took commonsense steps without making financial commitments that this country is unable to afford. Such items include insurance market reforms such as preventing denial of care for preexisting conditions, purchasing insurance across State lines, encouraging regional exchanges between States and portability, small business pooling and tax credits, negotiating drug prices, eliminating the $60 billion in Medicare fraud each year, rewarding efforts to prevent common disease and illness, enrolling those who qualify into existing programs like Medicaid and SCHIP, tax benefits for needy individuals for help purchasing insurance, and limiting abusive lawsuits.

Instead, we are confronted with a bill that overreaches by creating new government programs costing over $1 trillion paid for from tax increases and cuts to Medicare which are more gimmicks than real entitlement reform. Independent analysis of H.R. 3962 continues to show that reforms will result in higher costs for too many patients in addition to increasing the Federal debt which continues to rise dramatically under this Democratic administration and Congress.

Universal health care will not happen overnight. An incremental approach that expands access to health care coverage, contains costs and limits government involvement should be at the forefront of lasting and meaningful program. The process to date has been driven by politics. It is not too late to enact policies that enjoy broad bipartisan support.

Mr. ANDREWS. Mr. Speaker, our next speaker fought hard to make sure the vast majority of entrepreneurs in small businesses were exempt from any taxes under this bill. I am pleased to yield 1 minute to the gentleman from Colorado (Mr. POLIS).

□ 1845

Mr. POLIS. Mr. Speaker, I would like to thank Mr. ANDREWS, the committee staff, and Chairman MILLER for their hard work on this bill.

Where are we today? Our country spends more and gets less from health care. We spend more and get less. Many small businesses and individuals are unable to afford insurance. Americans are fed up with 15 to 20 percent increases in costs every year, and that is for those of us lucky enough to have insurance. People with preexisting conditions often can't get coverage, or the very condition they need coverage for is excluded.

Where does this bill take us? It encourages competition among insurance companies, giving us more choices and more stability so we can choose from hundreds of different policies, including shopping across State lines.

It covers most of the uninsured by empowering them to choose the provider of their choice. It prevents pricing discrimination based on preexisting conditions. It allows small businesses to have the same purchasing power as large corporations and saves them money. It reforms our legal system to reduce the cost of frivolous lawsuits. It supports doctor and nurse training, reduces the deficit by over $10 billion, and applies free market principles to establish a playing field for health care that is good for practitioners and consumers.

I encourage my colleagues to support health care.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to a member of the committee and the ranking member of the subcommittee, the gentleman from Kentucky (Mr. GUTHRIE).

Mr. GUTHRIE. Mr. Speaker, I have heard from many of my constituents who are worried and anxious about Speaker PELOSI's health care bill.

Speaker PELOSI's bill spends $1.2 trillion, cuts Medicare benefits, includes a $34 billion unfunded Medicaid mandate and increases premiums for those already struggling to pay for health insurance. On top of all of that, the bill raises taxes for just about everyone. The bill taxes individuals who choose not to purchase health insurance, taxes small businesses, taxes medical devices, and taxes health savings plans. The bill is the exact opposite of what the American people said they wanted.

The Republican alternative addresses Americans' number one priority for health care reform: lowering the cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without taxing families and small businesses.

I am voting ''no'' on Speaker PELOSI's bill because of the devastating consequences it will have on Kentucky's families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, we all know that our fiscal future presents enormous challenges. The skyrocketing costs of our health care system puts constraints on our Federal budget, on our family budgets, and it prevents necessary investments in our future and the future of our children.

The key to fiscal stability is entitlement reform. The key to entitlement reform is health care reform, and the first step in health care reform is the legislation before us. With nearly one-fifth of our national spending going towards health care, reducing the rate of increases in health care costs is an absolute necessity.

Let's be honest with our constituents. Reducing corporate welfare and promoting efficiencies in Medicare spending is not equivalent to cutting benefits or covering fewer services. Rather, the Affordable Health Care for America Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care.

Most importantly, the Affordable Health Care for America Act promotes stability and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote ''yes'' on H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, the health care system in America needs reform, but the Pelosi plan is the wrong prescription. Unlike the Republican plan, this bill does nothing to reduce health care costs.

While there are many reasons I am opposed to this bill, the most glaring is we can't afford it. Unemployment has hit 10.2 percent, the highest level since 1983; yet Democrats are forcing through yet another job-killing bill that, according to modeling created by the President's own economic advisers, will kill an additional 5.5 million jobs.

Kansas just announced it is facing a $460 million budget shortfall; yet this

body is set to send my State another unfunded mandate estimated to cost $230 million.

And the deficit just exceeded $1.4 trillion; yet the majority wants to pass this $1.3 trillion government takeover of health care.

Let's reject this fiscally irresponsible legislation.

Mr. ANDREWS. Mr. Speaker, may I inquire as to how much time each side has left?

The SPEAKER pro tempore (Mr. PASTOR of Arizona). The gentleman from New Jersey has 18 minutes remaining, and the gentleman from Minnesota has 21 minutes remaining.

Mr. ANDREWS. Mr. Speaker, I am very pleased to yield 1 minute to the newest member of our committee, who has made a tremendous contribution to this bill already, the gentlelady from California (Ms. CHU).

Ms. CHU. Mr. Speaker, I rise in strong support of the Affordable Health Care for America Act. The clock is ticking for Americans and the children of my district. Families have been suffering, waiting for changes in our health care system so they can care for their children. They have been waiting for Congress to act.

They are mothers like Maria, whose child has leukemia and worries that excessive copays will make her go bankrupt.

They are children like Stacey, who has been waiting to get glasses and can't see the chalkboard at school, but she can't get them because her parents' insurance doesn't provide vision care.

They are parents like Barbara and Jim, whose 20-year-old has diabetes and is no longer eligible for health insurance since he graduated from college.

With the passage of this bill, out-of-pocket expenses will be capped at $10,000, vision care for children will be covered, and older children will be covered up until age 26. Maria will not go bankrupt, Stacey will get glasses, and a son with diabetes can get treated. Children and families will get the quality health care they deserve.

Let's pass this health care bill now.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I am pleased to yield 1 minute to a member of the committee, a practicing physician himself, the gentleman from Louisiana (Dr. CASSIDY).

Mr. CASSIDY. Mr. Speaker, as a practicing physician, I know that this bill has tremendous consequences for patients and for the economy. It is estimated that the $730 billion in new taxes in this bill will kill 5.5 million jobs. The CBO estimates that this will have an annual inflation rate of 8 percent, an annual inflation rate that more than doubles costs in 10 years.

The Republican bill expands access by lowering premiums 10 percent. This bill expands access by forcing businesses and individuals to purchase, and if they do not, the long arm of the State reaches out and grabs them and shakes out fees and penalties.

Now, it was said this morning by a Democratic colleague that we need to redefine freedom. We are going to need all kinds of new definitions. We are going to redefine freedom as the ability to do what the government tells you to do. We are going to redefine helping the economy as higher taxes and destroying jobs. We are going to redefine bending the cost curve as more than doubling costs in 10 years.

Consider not the rhetoric, but the facts. Please reject this bill.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1½ minutes to the gentleman from New Jersey, my neighbor and friend, Mr. HOLT.

Mr. HOLT. Mr. Speaker, the question so many are asking is, Can we afford this health care reform? I would say not only can we afford it, we can't afford not to pass it.

Consider where we are today: Businesses, large and small, feel a heavy weight around their necks trying to afford health care for their employees. It hurts our economy. It costs jobs. Businesses and families are paying a hidden tax of over $1,000 each per year for the care of the uninsured. Costs continue to go up because our procedure-based system rewards the ordering of unnecessary and expensive tests that not only don't help the patient, they can be detrimental. Any family, even well-off families who think they have good health coverage, can find themselves in bankruptcy from a bad accident or arbitrary actions of the insurers.

All of this would change under this bill. This bill would reduce costs in a number of ways: By reducing the ranks of the uninsured, whose more expensive care we all pay for; by increasing the insurance competition through the new marketplace with a large interstate risk pool; by removing the antitrust exemption; and by moving toward more efficient record-keeping and by moving toward outcome-based, health outcome-based, patient-centered care.

In addition to all this, the revenues raised by this bill exceed the expenditures, so passing this will reduce the deficit by billions of dollars below what it would be if we do not pass this tonight.

We can't afford not to pass this health care reform. The bill will reduce the costs individuals, families and businesses face and reduce the government deficit.

Mr. HOLT. Mr. Speaker, I rise today in strong support of the Affordable Health Care for America Act, H.R. 3962, legislation that would provide secure and stable health coverage regardless of whether one changes jobs or is between jobs, ensure Americans will never be denied care if they get sick, and extend coverage to those Americans not well served by the current health care system.

This is a historic debate we are having. For the past century, since Teddy Roosevelt ran for President in 1912, our nation has been debating how to ensure that sick Americans can access the care they need. As a U.S. Representative and the husband of a primary care physician, I have heard many stories from hard-working New Jerseyans about the need for reform. Some Americans have access to excellent care, often thanks to the advanced biotechnology and pharmaceutical products created in New Jersey, while others lack even basic care. One of the goals of the health care reform is to help all Americans gain stable access to medical care and life-saving medicines.

At a July roundtable in Trenton, a spouse of a cancer patient told me that when she and her husband came home from the hospital after one extensive treatment, they returned to foot-high stacks of insurance paperwork and $150,000 of out-of-pocket charges for her husband's needed care. A self-employed woman from East Brunswick wrote to me recently to let me know she pays $2,000 a month for her family's coverage and still has to pay out-of-pocket to see many of her physicians. These stories are a reminder that health care reform is about real people who are disserved by the broken health insurance system.

These are not isolated stories. While in the U.S., we will spend over $8,000 per person this year for health care, 16 percent of New Jerseyans lacked insurance in 2007 and family insurance premiums are projected to rise from $14,000 in 2009 to $24,000 in 2019. In a country where we are projected to spend 18 percent of our Gross Domestic Product ($2.6 trillion) this year on health care, we can do better.

The Affordable Health Care for America Act would improve the American health care system for all Americans, regardless of how they currently receive their health coverage. First, the legislation would lead to stable health costs that do not threaten family finances by establishing consumer protections for those purchasing private insurance. The bill would eliminate insurance benefit caps to ensure families do not have to worry about leaving the hospital with bills too big to pay because their benefits have run out. The bill would set an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.

Second, the bill would provide stable coverage for those between jobs or the self-employed by creating an insurance marketplace, where they could get insurance at group rates. Most of the policies in this insurance marketplace would be private insurance, while one of the plans would be a non-profit public plan. This public plan would be subject to the same requirements and regulations as the for-profit plans in the marketplace. The public option would be just that—an option in which no one would be forced to enroll. The bill also would eliminate the practice where patients with a pre-existing condition like diabetes or cancer or pregnancy cannot purchase insurance. According to a Congressional committee report, the bill would help 10,000 uninsured individuals in Central New Jersey gain access to affordable health insurance.

Third, the bill would strengthen Medicare by starting to pay physicians for treating the whole patient and by encouraging doctors to coordinate a patient's medical care instead of paying for each test or procedure. The legislation would strengthen the long-term health of the Medicare trust fund by increasing the efficiency of the program, expanding its ability to fight waste, fraud, and abuse, and eliminating wasteful subsidies to private insurance companies.

It is worth repeating: not only would Medicare remain intact under this legislation, it would become better. The legislation would strengthen the Medicare trust fund by increasing the efficiency of the program, expanding its ability to fight waste, fraud, and abuse, and eliminating wasteful subsidies to private insurance companies. No standard Medicare benefits would be cut. In fact, Medicare would be improved by eliminating the ''doughnut hole'' in the prescription drug benefit. Each year in Central New Jersey, 8,300 seniors face the Medicare ''doughnut hole'' and are forced to pay their full drug costs, despite paying for Part D drug coverage every month. H.R. 3962 would provide these seniors with immediate relief by cutting brand name drug costs in the ''doughnut hole'' by 50 percent and ultimately eliminating the ''doughnut hole'' altogether. Further, the legislation would help seniors by eliminating co-payments and deductibles in Medicare for preventative services to ensure that diseases would be treated at their earliest stages and to keep seniors well. The legislation creates new Medicare incentives to encourage physicians and hospitals to coordinate medical care and seek to reduce duplicate tests, x-rays, and labs. These and other provisions are why AARP, among several others, has endorsed this health care reform legislation.

This bill was created from one of the most open and deliberative processes in recent memory. During the past few years, Congressional committees held more than 53 committee hearings, debated and voted on almost 240 amendments, and considered health reform for 167 hours. Many of the amendments reflected concerns raised by constituents and have improved this bill further.

While there are strong humane and moral reasons to pass this health reform bill, the economic reasons are equally strong. Businesses, large and small, feel a heavy weight in trying to afford health care for their employees—hurting the economy and costing jobs. Any family, regardless of their income, can find themselves in bankruptcy from one accident or expensive illness. All of this would change under this reform bill. The bill would lower health costs for families by increasing competition across all states through a new marketplace and eliminating the antitrust exemption. It would reduce costs by promoting coordinated medical care to eliminate duplicative tests, by simplifying insurance paperwork and electronic records. The bill would decrease costs by expanding research on which treatments work best for different patients, helping physicians and nurses provide effective medical care. Long term, the legislation would limit costs by shifting to a focus on health outcomes and rewarding physicians for treating the whole patient.

It would do all this without adding one penny to the debt. Instead, it will lower the debt and, according to the Congressional Budget Office (CBO), produce a $109 billion surplus over a decade. We cannot afford not to pass health care reform and reduce the crippling health costs facing our nation, our businesses, and our families.

Sadly, there is a great deal of misinformation about the proposed health reform bill. I have heard from some the myth that Members of Congress would be exempt from health care reform. It is worth noting that Members of Congress receive their health insurance like any other of the eight million federal employees and we pay premiums just like any other worker. The health insurance reform bill includes several improvements to the overall insurance marketplace, all of which would apply to the federal employee health insurance plans. I welcome the fact that the reform legislation would apply to Members of Congress, just like employees of other large companies.

Opponents of reform also claim that the House health reform bill would encourage euthanasia or insert the government into end-of-life conversations between patients and their physician. This claim is false. The truth is that the legislation would provide doctors with better payment for talking with their patients. This bi-partisan provision would provide payment for a doctor's time if a patient chooses to have a conversation about the care that the patient prefers if he or she becomes very ill, but it does not require anyone to use this benefit. These conversations would not involve any government employee, but would be solely between the patient and his or her physician. As noted by the AARP, ''[t]his measure would not only help people make the best decisions for themselves but also better ensure that their wishes are followed.''

There is no reasonable basis for concern that seniors' conversations with their doctors on personal requests for end-of-life care would do anything to promote assisted suicide, which is illegal in New Jersey and 47 other states, or euthanasia, which is illegal in all states.

Discussions between the sick or the elderly and their doctors about end-of-life care have long been an accepted part of modern patient care as a way to ensure that the patient's wishes are carried out. In 2003, under the Bush administration, the Agency for Healthcare Research and Quality issued a report outlining a five-part process for physicians to discuss end-of-life care with their patients. Unfortunately, doctors are not paid for such discussions and thus are not encouraged to have them. According to the National Hospice and Palliative Care Organization, which supports this provision, the bill simply would allow for counseling on decisions that require time and consideration.

Another myth is that health reform would provide federal benefits for undocumented aliens. Undocumented immigrants currently may not receive any federal benefits except in specific emergency medical situations. There are no provisions in the House health reform bill that would change this policy. In fact, the legislation explicitly states that federal funds for insurance would not be available to any individual who is not lawfully present in the United States.

I have heard from many constituents concerned about the inclusion or exclusion of family planning services in health insurance reform. The legislation would exclude federal funding of abortion, and maintain existing federal laws protecting conscience rights in health care. In fact, the amendment adopted tonight, which I believe is in error, would go further than existing law and even prevent women from using their personal funds from purchasing coverage for family planning services. I hope the conferees will revisit this issue to ensure women have the freedom to purchase the policy that best serves their needs and conscience.

I am pleased that health reform will help small businesses. According to a report issued from the Council of Economic Advisors in July 2009, the current health care system places a heavy burden on small businesses through high premiums, fixed administrative costs, adverse selection, and comparative disadvantage with larger businesses in America and with businesses in other countries. This is why small businesses pay up to 18 percent more per worker for the same health insurance plan than a large firm. The House legislation would help small business employees purchase insurance at group rates through an insurance marketplace, and by providing a tax credit to help small businesses that purchase insurance. Almost 18,000 small businesses in Central New Jersey would receive this tax credit.

The bill further recognizes the constraints facing small businesses and exempts many small employers from the shared responsibility requirement to provide insurance for their employees. The Congressional Budget Office and respected Massachusetts Institute of Technology health care economist Jonathan Gruber have pointed out that for the large majority of small businesses, the reform legislation would be a great improvement and would provide real savings.

For years, small businesses have asked me and other Members of Congress to allow them to get better rates by pooling their employees in large numbers, which is currently available to only larger companies. The newly-created marketplace would allow insurance plans to pool the health risks of millions of people and thus get lower rates. In addition to the marketplace for small businesses created by the House health reform bill, I worked with my colleagues Rep. PHIL HARE (D–IL) and Rep. ROB ANDREWS (D–NJ) to include language in this legislation that would allow affiliated small businesses to join together to purchase insurance. This proposal for helping small businesses was brought to me by a small businessman in my district.

I also was pleased to write a section of the bill that would create an online job training programs for health care workers, modeled after a successful program originating at Rutgers University. This program is needed to help meet the increasing need for health care workers, which was indicated by a July report by the Council on Economic Advisors. The demand for health workers soon will exceed the supply with 48 percent growth in health support occupations such as medical record, clinical laboratory, and health information technicians. My amendment, included in H.R. 3962, would provide new training opportunities to meet this additional demand for health professionals.

While I support the Affordable Health Care for America Act, I look forward to working with my colleagues to improve this bill as the legislative process moves forward. I have heard from home care and hospice providers in my district and across New Jersey who are concerned about the reductions in Medicare home health payments. I have spent time with home care organizations and with individual patients at home and have gained a deep understanding of the challenges and successes that occur each day. I fear that additional cuts to home health would make it harder to do the essential job that home care and hospice workers perform each day. I also am concerned that several provisions of the bill may impede biomedical research and innovation, as this research has improved patient care

and fostered a successful life sciences industry in New Jersey.

While the bill we are considering is strong, I know this bill will continue to improve as we move through the legislative process. Today's vote in the House of Representatives marks an important step in this process and is the furthest we have come toward providing affordable and quality health coverage to all Americans. I look forward to working to the completion of meaningful health care reform legislation and sending it to the President for his signature.

I urge my colleagues to vote in favor of this bill to reform our nation's health insurance system and improve.

Mr. KLINE of Minnesota. Mr. Speaker, before I recognize the gentleman from California, I yield myself such time as I may consume.

There has been quite a bit of discussion here about how this bill is going to help small businesses and reduce their taxes. I think it is no accident that business group after business group, small business after small business, large business after large business across this country is opposing this legislation. It is the businesses who are going to bear the first brunt of the taxes, bear the costs, and that is going to be relayed to lost jobs.

For example, I have a whole list of organizations: the Associated Builders and Contractors; the Associated General Contractors; the International Franchise Association; the National Association of Manufacturers; the National Federation of Independent Businesses; the U.S. Chamber of Commerce; and on and on, oppose this bill because it does not help business. It puts a burden on them.

Now I am pleased to yield 1 minute to the gentleman from California (Mr. MCCLINTOCK).

Mr. MCCLINTOCK. Mr. Speaker, the question before us comes to this: Will Congress force American families to surrender control of their health care to the Federal bureaucracy? There is nothing optional about this law. The word ''shall'' appears 3,400 times in it, each time backed with the full force of the government.

You shall only get your health care through the government exchange.

You shall only select among the health care plans that the government czar has approved for you, whether they fit your family's needs or not.

You shall buy a government-approved plan and pay for every government-imposed mandate in it through higher premiums, lower wages or higher taxes, and you will face steep fines and even Federal prison if you decline to do so.

You ''shall'' 3,400 times.

Whenever such a system is imposed, the result is always the same: massive cost overruns, followed by a brutal rationing of care.

Instead of destroying everything that is good about American health, shouldn't we first repair what is wrong? Primum non nocere—first, do no harm.

Mr. ANDREWS. I am honored to yield 1 minute to a gentleman who has done an extraordinarily effective job of representing his constituents, the gentleman from the Commonwealth of the Northern Mariana Islands (Mr. SABLAN).

Mr. SABLAN. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act. The need for health care reform has never been greater nor more urgent. This is true for my district, as it is for our Nation. We cannot wait another day. We must seize the moment and pass a law that will go a long way toward providing quality, accessible, and affordable health care for all Americans.

I urge my colleagues to support the bill.

Mr. KLINE of Minnesota. Mr. Speaker, I would like to yield 2 minutes to another physician, a member of the committee who is not only a doctor, but a small businessman, the gentleman from Tennessee (Dr. ROE).

(Mr. ROE of Tennessee asked and was given permission to revise and extend his remarks.)

Mr. ROE of Tennessee. Mr. Speaker, I thank the gentleman for yielding.

I rise in opposition to this bill before us. I came to Congress to enact health care reform. As a physician, I have seen firsthand the problems insurance companies created for my patients. I have seen firsthand how the government programs have made beneficiaries worse consumers of health care, and I have seen how the cost of health care has exploded and made insurance unaffordable. I want to fix these problems. But this bill will not fix these problems; it will make them worse.

The Democrats have ignored evidence that this program won't work. I asked President Obama three separate times since July to sit down and talk about the health care bill and what I know its effects will be, and I have yet to receive a call from the White House. It is one thing to disagree with the evidence that undermines the premise of reform you are pushing, but to not even consider it is unbelievable.

So here we are today with a health care bill that is over 2,000 pages. It is a Christmas tree of special interests. Sewer systems for Indian tribes, biofuel tax credits, nutrition standards for chain restaurants, and references to pizza and donuts all made it into this bill. But somehow the Democrats could not come up with a real solution for medical malpractice reform.

This bill taxes everyone and everything. It taxes medical devices, it taxes individuals, it taxes employers. It taxes small business owners who could be creating jobs and getting us out of this recession, instead forcing them to cut wages for jobs. It taxes medical savings accounts. It cuts Medicare. Home health care, skilled nursing facilities and Medicare Advantage would all be cut. And seniors with prescription drug coverage will have their premiums increased. Seniors oppose this bill because they get it. Their care is going to decrease and their costs are going up.

The bill spends all that money even faster. The bill dramatically expands Medicaid, despite the fact that I haven't heard anyone who had an option say they want to be on Medicaid. It creates a huge new Federal bureaucracy to navigate through. And it funds a government competitor to private insurance companies that will siphon people off the private insurance market onto a Medicaid-like program, just like Tennessee did with Tenncare.

Mr. Speaker, I came to Congress to enact health care reform. As a physician, I've seen firsthand the problems insurance companies created for patients. I've seen firsthand how government programs have made beneficiaries worse consumers of health care. I've seen how the cost of health care has exploded, so much so that many can't afford insurance. I've seen all these problems and I want to fix them.

When I first heard that the Democrats were proposing to insert a government competitor in the insurance marketplace, I thought, surely they can't be serious. When I realized they were, I thought I could change their opinions by telling them about the real-life failures I've seen under our state's program known as TennCare and how H.R. 3200 and now 3962 is simply a bad extension of these mistakes.

For months I've gone to the House floor with many of my physician colleagues to talk about the problems with this plan. The TennCare plan tried to provide universal coverage and make health insurance affordable, and in the end it nearly bankrupted the state as the program tripled in cost. It created an incentive for beneficiaries to seek unnecessary care because it cost them nothing. It shifted costs to the private plans, who were forced to make up the underpayments of the government program, increasing everyone's premiums. In the end, 45 percent of those on the public plan previously had private insurance and either dropped their coverage or were dropped by their employer.

Our Democratic Governor, Phil Bredesen, saved our state's budget by doing something hard—he cut the rolls. He controlled costs and he introduced an alternative plan called Cover Tennessee, which requires an equal contribution from employers, individuals and the government, which is a model for shared responsibility. Incidentally, Governor Bredesen has called this bill on the floor the mother of all unfunded mandates.

Democrats continued to ignore this evidence. I asked President Obama three separate times since July to sit down and talk about the health care bill and what I know its effects will be, and I have yet to receive a call from the White House. It's one thing to disagree with evidence that undermines the premise of the reform you're pushing, but to not even consider it is unbelievable.

So here we are today with a health care bill that is over two thousand pages. It's loaded up like a Christmas tree of special interest provisions. Sanitation facilities for Indian tribes, biofuel tax credits, nutrition standards for chain restaurants, and references to pizza and doughnuts all made it into this bill, but

somehow, Democrats could not come up with a real solution for medical malpractice reform except to try to protect trial lawyers' share of jury awards. Malpractice is proven to cost the health care system billions of dollars every year, but the reforms being proposed make the current system worse.

This bill taxes everyone and everything. It taxes medical devices. It taxes individuals who choose not to purchase insurance, and drives up premiums for individuals who do purchase insurance. It taxes employers who fail to offer health insurance, then taxes them further if they try to increase their employees' wages. It taxes small business owners, who could be creating jobs and getting us out of the recession, and instead forces them to cut jobs or wages. It taxes health savings accounts, which reduces the use of catastrophic health insurance coverage.

It cuts Medicare. Home health care, skilled nursing facilities and Medicare Advantage would all be cut, and seniors with prescription drug coverage will have their premiums increased. Seniors oppose this bill because they get it—their care is going to be decreased and costs are going up.

After the bill finishes up taxing everything and everyone, it spends all that money even faster. The bill dramatically expands Medicaid, despite the fact that I've never heard of anyone saying they want access to the program. It creates a huge new federal bureaucracy to navigate through. And it funds a government competitor to private insurance companies that will siphon people off of private insurance onto a Medicaid-like program, just like Tennessee did with TennCare.

After the Democrats finish spending $1.5 trillion, they say the bill is quote unquote deficit neutral. But they ignore that every major government health care expansion before it—Medicare, Medicaid, SCHIP to name a few—have cost more than originally estimated. And they completely ignore the fact that they use 10 years of revenue to pay for 7 years of new spending. In the second decade, this program will become an enormous unfunded mandate on state governments, on individuals and on the federal government. Despite the largest deficit in our nation's history, the Democrats are irresponsibly going to make it harder to ever balance the budget.

Here's the bottom line: this bill costs too much. It taxes too much. It does nothing to improve health care, and will result in the majority of Americans left with decreased access, decreased quality and increased costs. It is, as the Wall Street Journal called it, the worst bill ever and deserves to be rejected.

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Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to the gentlewoman from New York (Ms. Clarke), one of the leading voices for senior citizens, resulting in the AARP endorsing our bill.

Ms. CLARKE. I thank the gentleman from New Jersey very much.

Mr. Speaker, today I rise to support H.R. 3962, the Affordable Health Care for America Act. As we approach the dawning of the second decade of the new millennium, this evening we will usher in a new assurance of the health and well-being of all Americans. Our children will have the health and peace of mind to exceed the productivity of our generation. Our willingness to do what it takes to transition into the 21st century health care delivery system will guarantee future generations the advancement of a productive civil society.

Every American has a right to adequate physical and mental health care, and I believe that we, as a national government, have a responsibility to assist our citizenry in securing quality health care. It is unfortunate that there are those amongst us who just couldn't care less; those who were satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of preexisting conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Mr. Speaker, I urge all of my colleagues to vote for this measure.

Mr. Speaker, today, I rise in support of H.R. 3962, Affordable Healthcare for America Act. This evening, as we approach the dawning of the second decade of the new millennium, we will usher in a new assurance of the health and well being of all Americans. Our children will have the health and peace of mind to exceed the productivity of our generation. Our willingness to do what it takes to transition to a 21st century healthcare delivery system will guarantee future generations the advancement of a productive civil society.

In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance, 13.5 percent of whom are New Yorkers. Last year alone, New York City's hospitals spent $1.2 billion in charity costs. Tragically, people who are either uninsured or underinsured often have to go without vital healthcare simply because they cannot afford it.

Every American has a human right to adequate physical and mental healthcare, and I believe that we as a national government have a responsibility to assist our citizens in securing quality healthcare.

Unfortunately, my Republican colleagues don't seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare.

It is unfortunate that there are those amongst us who just could care less—those who are satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of pre-existing conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Instead of working with us to fix the problem, they capitalize on people's fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens. Today we will not allow the voices of fear to dominate the healthcare reform debate.

This bill provides healthcare coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Healthcare for America Act.

With preventative care as the cornerstone of the 21st century healthcare delivery system, eliminating the disparate treatment of women, eliminating discrimination based on pre-existing conditions, creates a new health exchange for access to quality affordable health insurance and turns medical visits from a broken volume based system to a 21st century value based system. I will cast my vote this evening in memory of a distinguished New Yorker, Brooklynite and friend Jackie Ward, who died of heart failure as a young woman in her early 50s.

In my district, the 11th Congressional District of Brooklyn, the Affordable Healthcare for America Act will: First, improve employer-based coverage for 367,000 residents. As a result of the insurance reforms in the bill, there will be no co-pays or deductibles for preventative care; no more rate increases or coverage denials for pre-existing conditions, gender, or occupation; and guaranteed oral, vision, and hearing benefits for children. Second, it will provide credits to help pay for coverage for up to 160,000 households, if they need to purchase their own coverage. Third, under the bill's insurance reforms, 11,900 individuals in the district who have pre-existing medical conditions will now be able to purchase affordable coverage. Finally, this bill will allow 11,300 small businesses to obtain affordable healthcare coverage and provide tax credits to help reduce health insurance costs for up to 11,400 small businesses.

Healthcare is a fundamental human right, rather than a commodity. A year ago, Americans cast a historic vote to change the course of this Nation. Today, we cast this historic vote, to finally manifest the change they demanded: Access to Affordable Healthcare. I am proud to cast my vote in favor of this bill.

Mr. KLINE of Minnesota. Mr. Speaker, may I inquire as to the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Minnesota has 16 minutes. The gentleman from New Jersey has 14 minutes.

Mr. KLINE of Minnesota. Thank you, Mr. Speaker.

At this time I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. THOMPSON), a member of the committee.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I rise today in opposition to H.R. 3962. I came to Congress this past January following 28 years in nonprofit health care. In January, the Democratic majority quickly moved the SCHIP reauthorization. I supported the final passage of the bill. SCHIP was modeled after Pennsylvania's CHIP program, a bipartisan public-private partnership to offer private insurance to my State's most vulnerable population. CHIP works in Pennsylvania.

Mr. Speaker, I am dismayed to learn that this bill will scrap the SCHIP program. This will jeopardize coverage and increase costs for scores of Pennsylvania's needy children. Families who rely on Pennsylvania's CHIP program will faces higher costs when their children are forced into plans offered through the exchange. We have heard from my colleagues about cuts to our seniors, small businesses, family farms, and agriculture. Now you are hearing about the cost to our children.

As a health professional, I urge my colleagues to vote ''no'' on this measure, and I would like to submit a letter from five of my Republican colleagues from Pennsylvania on this issue.

CONGRESS OF THE UNITED STATES
Washington, DC, November 7, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives, The Capitol, Washington, DC.

DEAR SPEAKER PELOSI: We are writing to express our grave concerns with provisions included in H.R. 3962, the Affordable Health Care for America Act, that would eliminate the Children's Health Insurance Program (CHIP) and require all children above 150 percent of the federal poverty level (FPL) who are not covered under a Medicaid CHIP (M–CHIP) expansion program to be moved into the new health insurance exchange. These extremely troubling provisions will add an undue cost burden on children and families in Pennsylvania as well as delays in care and coverage gaps when CHIP plans are terminated.

Members of the Pennsylvania General Assembly strongly advocated for the creation of Pennsylvania's CHIP law in 1992, and improvements to the program in 1997. Our program served as a model for the federal CHIP law, and it has been an overwhelming success in our state. There is no better example of a public-private health partnership that has contributed to the lives of Pennsylvania families. We often hear from our constituents that their children are healthy and active because of CHIP.

Now, only months after you championed for the reauthorization of CHIP, it is surprising that the bill you are ushering through the House is proposing to eliminate this successful program. These provisions would jeopardize coverage and increase costs for scores of Pennsylvania's children since Pennsylvania operates CHIP as a separate program and makes coverage available to children beyond 150 percent of FPL.

A recent actuarial analysis demonstrates that CHIP benefits are superior for low-income families than the House health care legislation. Families who rely on Pennsylvania's CHIP program will face higher costs when their children are forced into the plans offered through the exchange. For instance, for children living in families earning 175 percent of FPL, the study finds that the median CHIP plan covers 100 percent of medical expenses covered by CHIP. Under the House bill, that family will pay nearly 400 dollars. For children in families earning 225 percent of FPL the median CHIP plan covers 98 percent of medical expenses, exposing children to only 2 percent of costs. Comparable exchange plans would expose families to 5 percent to 35 percent of out-of pocket costs.

We have witnessed first hand that CHIP is an efficient program that provides Pennsylvania children with affordable, quality care. H.R. 3962 is a step in the wrong direction for our children—imposing higher costs and delivering fewer benefits to our most vulnerable population.

For several additional reasons, we will vote against H.R. 3962. Protecting children, especially those most in need, should be one of Congress's top priorities in the context of health care reform. We urge you to reconsider the direction H.R. 3962 will lead this country and the consequences of eliminating CHIP for Pennsylvania's children.

Sincerely,

CHARLES W. DENT,
Member of Congress.
TODD RUSSELL PLATTS,
Member of Congress.
BILL SHUSTER,
Member of Congress.
JIM GERLACH,
Member of Congress.
GLENN THOMPSON,
Member of Congress.

Mr. ANDREWS. Mr. Speaker, I yield myself 3 minutes.

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. I would like to thank my friends on both sides of the aisle. This has been a stressful time for Americans, and today may have been a very stressful day for Americans.

This might have been the day that someone thought they were going to get a job but found out that they won't get the job because they had breast cancer 5 years ago and can't get health insurance because of their preexisting condition. It has not been their day.

Or it might be the day that a senior citizen decides that they don't have the money this week to renew their prescription because they're in the doughnut hole under Medicare. So they're going to pay their rent instead of their prescription bill, and they're going to get very sick. It's just not their day.

Or it might be the day that someone is lying awake in bed, churning about the fact that their child seems a little sicker than usual. But if they take them to the doctor, they might get sent to the hospital, and they can't pay the hospital bill because they have no health insurance, and it might mean bankruptcy or foreclosure or losing their home. It's just not their day.

If we pass this bill and it gets to the President's desk, a new day will come to this country, because no person with a preexisting condition will ever suffer discrimination again; because effective next year, eventually no senior will run out of drug coverage at any time during the year because they work for it and they deserve it. The new day will come to that uninsured person because no hardworking American will ever go without health insurance in this country.

You know, the special interests and the lobbyists and the health insurance industry, they have all had their day. They have been around here for a very long time. And I hate to disappoint them, but today is not their day. It is the day for uninsured Americans. It is the day for hardworking Americans. This is the day when we will begin the change, and every American will get the health care they so richly deserve.

Stand up for those who cannot be heard, and vote ''yes'' for this bill.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. EHLERS), a member of the committee.

Mr. EHLERS. Mr. Speaker, I certainly support making health care more affordable and accessible for all Americans. Perhaps I'm naive, but I had hoped that we would have been able to produce a bipartisan bill that I could gladly vote for. Such is not the case. We were not even given the courtesy by the other party of taking part in writing this bill and presenting ideas which could be included in the bill.

The status quo in the health care system is unacceptable. We must make health care more affordable and accessible than it is. But this bill is even less acceptable than the current health care system. This bill will result in large tax increases, as we've heard, which is absolutely the last thing that my State of Michigan needs because we are struggling so hard with the economy the way it is. This proposed bill is basically a government takeover.

What am I looking for? I'm looking for health care quality. That, to me, means getting the treatment you need, when you need it, from the doctor you choose. This bill does nothing to provide that.

Time is a great health care killer among governments. We looked at other countries. They may have very good plans, but if you need an MRI today and you have to wait for 6 months, you are not getting good health care. We want to make sure that the plan we develop provides the health care you need, when you need it, from the doctor you choose.

I truly hope that, in the future, as we go through the conference process with the Senate, that our Republican ideas will be incorporated as well as the Democratic ideas, and that we really produce the best bill we can. We did that with Medicare. We tried to do it with Medicare part D, and I would hope that the Democratic Party, instead of just glorying in their bill, and doing their own thing, and ignoring the Republicans, would, in fact, work with us and try to produce a bill that is good for the country, for the people, and especially for those who need medical care.

The SPEAKER pro tempore. Without objection, the gentleman from California (Mr. GEORGE MILLER) will control the remainder of the time.

There was no objection.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentleman from Ohio (Mr. WILSON).

Mr. WILSON of Ohio. Mr. Speaker, as we wind down the clock on the health care debate, I have thought long and hard about what's best for my district back in Ohio, and I have concluded that the Affordable Health Care for America Act is an important step forward in fixing our broken health care system.

While this legislation is not perfect, there are benefits that are simply too hard to ignore. For example, in my district, 13,000 small businesses will have the opportunity to provide their employees better health care. We will close the drug doughnut hole for over 9,000 seniors just in my district alone, and it will help 174,000 households in the Sixth Congressional District afford better coverage.

I have always promised the people that I work for back home that I will vote in their best interest and that I will stand up for what is right. I am

proud to be here this evening on this issue, and I believe that this bill is the right thing to do to provide stability and security for the families in Ohio in my district.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased to yield 1 minute to my colleague, the gentlewoman from my home State of Minnesota (Mrs. BACHMANN).

Mrs. BACHMANN. Mr. Speaker, the American people overwhelmingly reject the government takeover of our health care. Last Friday, a couple from Hawaii decided the time is so short they needed to get on a plane, come to Washington to beg their Representative to vote ''no'' from Hawaii. What sacrifices freedom-loving Americans are making to get their government's attention and how big our government has gotten.

They brought me this beautiful, precious lei, and I am reminded that the one who created this lei also created our freedom. Are we so insensible to the high cost our forebears paid to purchase our freedom? Tonight, would we foolishly bargain those freedoms away? The American people, our forebears, generations yet unborn, are crying out to us tonight for us to preserve their freedoms.

Vote ''no'' on the government takeover of health care.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentlewoman from Pennsylvania (Mrs. DAHLKEMPER).

Mrs. DAHLKEMPER. Mr. Speaker, the American people overwhelmingly have called on us, their Representatives, to enact real change in our country and in their lives. The Affordable Health Care for America Act embodies the positive change the American people have demanded.

This bill creates effective, affordable, and quality reform for all Americans. Seniors will benefit from a stronger Medicare system, no longer subject to the prescription drug doughnut hole or have to pay out of pocket for their primary care needs. Small businesses will no longer be burdened by skyrocketing health care costs. Tax credits and greater competition in the health care market will make coverage affordable for these small businesses, and no individual will ever again be denied health insurance because of preexisting or chronic conditions.

My colleagues, the need for reform is clear, and the time for reform is now. I urge Members on both sides of the aisle to vote for the Affordable Health Care for America Act for our seniors, for all women, for small businesses, and mostly for our precious children and grandchildren.

Mr. KLINE of Minnesota. Mr. Speaker, at this time, I yield 1 minute to the gentleman from Texas (Mr. SMITH), the ranking member of the Judiciary Committee.

Mr. SMITH of Texas. Mr. Speaker, I thank the gentleman from Minnesota, the ranking member of the committee, for yielding me time.

According to CBO estimates, this bill will cost $1.3 trillion and includes $750 billion in new taxes and $500 billion in Medicare cuts. It increases premiums, increases taxes, cuts benefits, and leads to health care rationing. The government, rather than patients and doctors, will make many health care decisions. The bill represents a loss of freedom and more government control for the American people.

I support health care reform to help the long-term, low-income uninsured, but it can be achieved without a government takeover of health care. The House Republicans have a better health care bill that lowers premiums for families and small business owners, cuts the deficit by $68 billion, and includes tort reform.

Mr. GEORGE MILLER of California. If I could inquire of the Chair as to how much time is remaining on both sides.

The SPEAKER pro tempore. The gentleman from California has 10 minutes. The gentleman from Minnesota has 11 minutes.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentleman from Missouri (Mr. CARNAHAN).

Mr. CARNAHAN. Mr. Speaker, ''millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.'' President Truman delivered these words in a special message to Congress in 1945, calling for comprehensive health care in America.

Health care in America has been broken far too long, unavailable and unfair for too many, becoming more unaffordable every year. Health care premiums have doubled in 10 years. Health care bills are the number one reason for personal bankruptcies in our country. Health care costs are the number one contributor to our deficit. We spend more on health care than any other country, yet we rank near the bottom in terms of health care results.

This bill builds upon the best parts of our private employer-based system and fixes what's broken to lower costs, increase competition, promote preventive medicine, and protect seniors. Many ideas and concerns from Missourians I represent have been included in this bill to make it even better. History and the American people are calling us to action. The time is now to fix health care in America.

Mr. KLINE of Minnesota. Mr. Speaker, now I yield 1 minute to the gentleman from Alabama (Mr. ADERHOLT).

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Mr. ADERHOLT. Mr. Speaker, there is no question we need to address health care problems in this Nation. That is something both Democrats and Republicans both agree on.

However, the government takeover of health care that we are debating tonight adds up to way too much spending, too much government bureaucracy, too many unfair mandates, too much government control in an area with where government just doesn't belong.

The Republican substitute is about to be debated tonight, and it will attempt to fix the broken aspects of health care in the United States. There will be many of us tonight in this Chamber who will vote ''yes'' on that Republican substitute because there needs to be changes. However, we will vote ''no'' on final passage because we don't want to throw the baby out with the bath water in order to fix the problems.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. SCHAUER).

Mr. SCHAUER. Mr. Speaker, because of rising medical costs, families in America are literally going broke. Yes, broke. The American Journal of Medicine reported that 62 percent of American bankruptcies are linked to medical bills. These medical bankruptcies have increased by 50 percent in just 6 years. The shocking fact is that 78 percent of these people actually had health insurance, but gaps and inadequacies in the current system left them unprotected when they were hit by devastating bills.

Important insurance reforms in this bill will fix this, and as a result of this bill, 36,000 of my constituents will finally be able to afford quality health coverage and peace of mind for their families.

Perhaps more than in any other State, people in Michigan know that the current system is broken. It's time for us to fix it. It's time for us to pass H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. I thank the gentleman for yielding.

Government can't give until it takes. There is no such thing as a free lunch.

You know, we have 10.2 percent unemployment right now. This bill is going to cost about 5.5 million jobs. It's going to cost $730 billion in new taxes and $1.2 trillion for the program over the next decade. We can't afford that at this time with unemployment being at the rate that it is.

We face a $1.4 trillion deficit this year alone, and you're going to add $1.2 trillion to that and a $730 billion tax increase with 10.2 percent unemployment?

You're going to cost jobs. And the American people want jobs right now, first and foremost. Jobs. Jobs. Jobs. And then deal with some of these things in a more responsible way.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to our new Member from New York (Mr. OWENS).

Mr. OWENS. Mr. Speaker, my district needs one thing: jobs.

In Upstate New York small businesses are the jobs engine. Over the past 15 years, they have been responsible for nearly two-thirds of all jobs

created in America. But the cost of health care is grinding the engine down. Over the last decade, small business insurance premiums are up 129 percent. That means much higher expenses, more businesses dropping coverage, a sicker, more financially strapped workforce, and enormous pressure on small business owners from competitors overseas and big businesses at home.

The bill can change that. It creates a competitive marketplace where individuals and small businesses can shop for policies at fair rates. It guarantees free preventative care for a healthier, more productive workforce. And it encourages Americans to start businesses of their own because the cost of health care will no longer tie them to the same job.

The people of my district need jobs. They need me to vote ''yes.'' I came to Congress to move America forward. This will do that.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 3 minutes to the distinguished Republican leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

For many of us on both sides of the aisle who believe in the sanctity of human life, the underlying bill allows for taxpayer funding of abortion. The Speaker has allowed Mr. STUPAK and others to offer an amendment tonight.

And, Mr. MILLER, if that amendment were to pass and this bill were to get to conference and there were a vote in the conference on this, would you guarantee me that you would support the House-passed version?

Mr. GEORGE MILLER of California. Will the gentleman yield?

Mr. BOEHNER. I'm happy to yield.

Mr. GEORGE MILLER of California. As he has already acknowledged, when he was Chair and he went to conference many times, he could not guarantee anything. You will take into this House, if that amendment should pass, that will be an expression of this House on that subject, on that amendment. We will take that with the full dignity of that vote into that conference committee.

Mr. BOEHNER, if you can speak for the Senate—nobody else has been able to.

Mr. BOEHNER. Reclaiming my time, the question was this: If the House is to pass the Stupak amendment and this bill is to pass tonight and there is a vote in the conference on this issue, would you guarantee me that you will support the House-passed version?

Mr. GEORGE MILLER of California. I will not guarantee that. You know the nature of the conference committee.

Mr. BOEHNER. Reclaiming my time, this is the third chairman tonight who will provide no guarantees that if the House were to pass the Stupak amendment that they would vote in committee to support the House-passed version.

This is the point of why I've been down here making this an issue: just because we pass an amendment to help facilitate the passage of what I think is a bad bill does not mean that the language that this House votes on is committed to by the Democrat leaders in this House.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to our new Member to the Congress from California, Congressman GARAMENDI.

Mr. GARAMENDI. Mr. Speaker, 3 days ago I had the great honor of joining this august body, which for more than a century has debated health care.

Two hours ago a dear friend Chic Dambach and his adult son came to my office. At the age of 2, Kai's kidneys failed. Chic and his family had health insurance. Their insurance company refused to cover transplants. Chic and his wife, Kay, were faced with a choice: enormous personal debt or their son's life. They chose life.

A decade of battles with their insurance company together with crushing debt, Kai, when he becomes 23, will be uninsurable. He has a preexisting condition.

H.R. 3962 is America's opportunity to end this despicable situation. The bill has strong comprehensive insurance reform and creates the penultimate enforcement mechanism: the public option. Americans should not be at risk any longer. The bill deserves our support.

Mr. Speaker, three days ago I had the great honor of joining this august body that for 220 years has debated the momentous issues of the day, wars, industrial and labor policy, civil rights, environmental protection, and social security, and for more than a century—health care policy.

Today we are faced with a choice. Do we vote no health insurance reform and continue the current situation that has placed in jeopardy every person in America who is not yet 65 years of age? Or do we vote today to provide every American with a comprehensive, affordable, and available health care policy?

One example of why we must vote yes on H.R. 3962 and end the health care crisis that millions of Americans face each year is Chic Dambach and his son Kai.

Some of you may know Chic as the former President of the Returned Peace Corps Association. Chic and his family had a comprehensive family health insurance policy. At the age of two, Kai's kidneys failed.

Their insurance company refused coverage for kidney transplants. Chic and his wife Kay were faced with a choice, more than a hundred thousand dollars of personal debt or their son's life. They chose life.

Today, Kai is a freshman at the University of Maryland. More than a decade of battles with their insurance company has ensued together with a crushing burden of debt. When Kai becomes 23 he will be uninsurable. Like millions of other American's he has a preexisting condition.

H.R. 3962 is America's opportunity to end this despicable situation. The bill has strong comprehensive insurance reform and creates the penultimate enforcement mechanism—The public option—that in its fullness would allow all of us to walk away from the clutches of the profit before people private insurance companies whose first operating commandment is ''Pay as little as late as possible.''

This must end. Americans should not be at risk any longer. H.R. 3962 is the solution. It deserves our support.

Mr. KLINE of Minnesota. Mr. Speaker, I yield for the purpose of making a unanimous consent request to the gentleman from Pennsylvania (Mr. DENT).

(Mr. DENT asked and was given permission to revise and extend his remarks.)

Mr. DENT. Mr. Speaker, I rise in opposition to this government takeover bill.

Mr. Speaker, I rise today to ask unanimous consent to revise and extend my remarks and have them submitted to the CONGRESSIONAL RECORD.

I have spent the past week reviewing the 1,990 page health-care bill—H.R. 3962—that was introduced last Thursday and the manager's amendment that was filed late Tuesday night. I oppose this legislation which will exacerbate rather than solve the problems in our health care system and take our Nation in the wrong direction.

Although I believe health care reform is needed, diminishing Americans' control over their health care decisions, cutting Medicare benefits for seniors, eliminating SCHIP coverage for low-income children, imposing punitive taxes on small businesses and increasing health care costs for all Americans in order to create an unsustainable entitlement program that will bury our Nation in debt is not the way to do it. Fundamentally, this bill moves the United States in the direction of a European style welfare state which is accompanied by much higher European style tax rates, slower economic growth and structurally higher unemployment rates. The bottom line is that this legislation will lead to fewer opportunities for our children and grandchildren.

H.R. 3962 is bad for Americans because it won't reduce health care costs—in fact many will see increased costs—and it will cause millions of working Americans to lose their current coverage.

It's bad for seniors. The bill includes nearly a half-trillion dollars in cuts to Medicare benefits. It will mean less choices, as well as increased premiums and prescription drugs costs for thousands of seniors in the 15th District.

It's bad for Pennsylvania's children, who will be forced out of the State's successful CHIP program into plans offered through the health insurance exchange where families will face higher costs.

It's bad for Pennsylvania's already struggling budget, forcing an unfunded Medicaid mandate of at least $2.2 billion on our cash-strapped Commonwealth.

It's bad for small businesses. It will stifle innovation and job creation by imposing punitive surtaxes. It's bad for the Pennsylvania economy in particular, with a $20 billion tax on the makers of medical devices, an industry that employs thousands in my district and the surrounding region.

And above all it's bad for America, spending more than $1 trillion in taxpayer dollars to create an unsustainable new Federal program and saddling our children and grandchildren with debt. Only in Washington can someone say with a straight face that by creating a new

trillion dollar program that we will not add a dime to the deficit now or in the future.

If we are serious about enacting meaningful health care reform that will ensure that all Americans have access to quality care, we must address the issue of cost. American families are struggling to afford increasing health care costs and health care spending is taking up a larger and larger portion of Federal, State, and local governments' budgets.

Regrettably, H.R. 3962 fails to address one of the key reforms that will save billions of dollars and reduce health care costs—medical liability reform. In fact, the provisions in H.R. 3962 will actually heighten the medical liability crisis facing our Nation.

The medical justice system is one of the major drivers of cost in our health care system. Doctors practice defensive medicine—ordering tests and treatments that are not truly needed but prescribed to ward off frivolous lawsuits. We have all been in our doctor's office and thought, ''Do I really need this?'' This defensive medicine doesn't mean better care; it just means more expensive care. The litigious environment has caused medical liability insurance premiums to skyrocket. In turn, patients pay more for health care because the costs are passed down.

The practice of defensive medicine costs the United States more than $100 billion per year—some studies have estimated the cost may be as high as $151 billion to $210 billion annually. In Pennsylvania, not only are medical liability insurance rates increasing costs for patients, they are driving qualified doctors out of the Commonwealth.

Recently, the Congressional Budget Office, CBO, released an analysis indicating that medical liability reforms would save the government $54 billion over 10 years and cut national healthcare spending by 0.5 percent a year. These savings would be the result of direct savings from lower premiums for medical liability insurance and also indirect savings from reduced utilization of health care services.

The original House health care bill, H.R. 3200, was silent on medical liability reform. Just 3 of the 1,990 pages of H.R. 3962 address the issue. Tragically, the language in H.R. 3962 actually discourages States from making the medical liability reforms that CBO has said will save $54 billion. This is politics at its worst—protecting trial lawyers at the expense of patients.

Yesterday, I offered an amendment to the Rules Committee that would have inserted significant medical liability reform provisions into H.R. 3962. My amendment would enact nationwide reforms aimed at ending the costly practice of defensive medicine and encourage States to adopt effective alternative medical liability laws that will reduce the number of health care lawsuits initiated, reduce the average amount of time taken to resolve lawsuits and reduce the cost of malpractice insurance. Specifically, I believe we must stabilize compensation for injured patients, hold parties responsible for their degree of fault, ensure that meritorious claims are swiftly resolved, encourage compliance with accepted clinical practice guidelines, and guarantee that medical care is available to those who need it the most by providing protections to safety-net providers.

Unfortunately the leadership in the U.S. House of Representatives made the choice to prohibit meaningful reform from being debated on the House floor today. I sincerely regret that the majority decided to bulldoze ahead without considering practical policy that will reduce costs and produce significant savings in our health care system.

With common sense, bipartisan discussion, we can make straightforward reforms to our health care system that will address the most pressing problems. We can enact strong insurance market reforms that provide consumer protections and promote transparency. We can ensure that those with chronic conditions and preexisting conditions have coverage through high-risk pools and reinsurance models. We can actually lower the cost of health care and increase access to affordable coverage by removing restrictive barriers on competition across state lines, allowing businesses to pool together and get the same buying power as their larger competitors, equalizing tax treatment for individuals buying health insurance, and enacting meaningful medical liability reform. We can put our Nation on the path to a healthier future by focusing on prevention and wellness.

Today, the House majority has failed the American people. Now the Senate has an opportunity to prevent this ill-conceived measure from moving forward, and embrace the calls of the American people to unite behind meaningful reforms that will reduce cost and increase access without fundamentally altering the American economy.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Speaker, I rise today to oppose the Democrats' government takeover of health care.

This bill will raise taxes on individuals and small businesses, cut Medicare for seniors, and raise health care premiums. The bill raises taxes by $730 billion and costs nearly $1.3 trillion. We literally cannot afford this plan.

There is a better way, however. The Republican health care plan is a responsible, targeted approach to reform. It doesn't raise taxes during a recession or cut Medicare. It will lower premiums, making coverage more affordable for families and employers while reducing the deficit by $68 billion. Commonsense ideas like medical liability reform, strengthening association health plans, and allowing people to purchase health insurance across State lines will make health care more affordable without breaking the bank.

The choice is simple. Mr. Speaker, I urge my colleagues to oppose Speaker PELOSI's health care bill and support the Republican alternative.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from Maryland (Ms. EDWARDS).

Ms. EDWARDS of Maryland. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of this historic legislation. It is the most historic in a generation. H.R. 3962 will indeed change the face of health care in this country. This bill really is not about partisanship and it's not about politics, but it is about the American people; and it's time for us to deliver on our promise to them.

As I've listened to my colleagues today talk about why this bill is good for their districts for the uninsured, for men, for women, for our seniors, I'm reminded that I was indeed once one of those uninsured. As a young mother, I became so sick that I collapsed in a grocery store, and I was taken to an emergency room. Without health care insurance, I was treated. I was one of those uncompensated. Now it's time for me to pay the American people back with a vote for comprehensive health care reform.

This bill will take the burden off providers and Americans for paying the cost of uncompensated care and safeguards for the health of all Americans. It lowers costs and ends discriminatory insurance industry practices such as denying women coverage for pregnancies or a history of domestic violence.

Mr. Speaker, it's time for us to have the courage to rise above our pecuniary interests.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I'm very pleased to yield 1 minute to my friend and colleague, the gentleman from Ohio (Mr. JORDAN).

Mr. JORDAN of Ohio. I thank the gentleman for yielding.

Mr. Speaker, how bad does it have to get? How bad does it have to get before we stop the out-of-control spending? A $1.4 trillion deficit, a $12 trillion national debt, a trillion dollars in bailouts and stimulus, and now here we come again with $1.3 trillion takeover of our health care system.

One of the things that makes this country so special, one of the things that makes this country the greatest Nation in history is this simple concept, that parents make sacrifices for their children so that when they grow up, they can have life a little better than we did, and then they in turn do it for the next generation, and each generation in this country has done it for the one that succeeds them.

And now, unfortunately, what we are doing is borrowing and spending and living for the moment and passing the bill on to our kids. It's wrong and it should stop here.

Vote this bill down. Support the Republican alternative.

Mr. KLINE of Minnesota. Mr. Speaker, can I inquire as to exactly the time remaining for each side.

The SPEAKER pro tempore. The gentleman from Minnesota has 5 minutes remaining, and the gentleman from California has 5 minutes remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from Kansas (Mr. MORAN).

Mr. MORAN of Kansas. Mr. Speaker, the Pelosi health care bill creates 111 new bureaucracies and it only cuts one program: Medicare.

I chair the Rural Health Care Coalition. I care about health care especially as it affects rural States, rural

Americans like Kansans. And I have concluded that this bill will not make health care more affordable or more accessible for rural America. The standard by which I judge this is not a Republican plan or a Democrat plan, but what is good and right for America.

I've concluded that coupled with all the other bad ideas of this Congress—stimulus packages, bailouts, Cash for Clunkers, cap-and-trade—we will be leaving our children with more debt, less freedom, diminished personal responsibility, and fewer economic opportunities. Worse, we will have failed to honor the dreams for a better life for another generation of Americans. This I will not, cannot support.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

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Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in strong support of this bill, H.R. 3962, the Affordable Health Care for America Act. It is a long time we should have been here. We have been trying this for so very long.

You know, if this bill said anything as bad as what I have heard from the Republicans, I wouldn't support it. But it does not do that. I don't know what bill they are reading.

I want to share, though, that I know this will bring relief to my constituents. In my district, there are 35.6 percent of the residents uninsured, and the adjoining district, District 32 of Texas, has about the same number, but we are on different sides for bringing that relief.

The American people have heard so many untruths, they must be confused. Having access, though, to better coverage will show them what the truth is. This bill is a win for all Americans. I stand in strong support of this legislation and urge my colleagues to vote in favor of this bill.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased to yield 1 minute to another physician, the gentleman from Louisiana (Dr. FLEMING).

Mr. FLEMING. It has been mentioned many times during this debate that the AMA and the AARP have endorsed this. However, the polls show that the majority of physicians oppose this. And the polls say that the majority of seniors oppose this bill, the Pelosi health care takeover.

Who is going to be hurt in this? Individuals will be required to pay 2.5 percent taxes or go to jail; 5.5 million of them will be unemployed. Businesses will be required to pay 8 percent payroll tax, and then an additional excise tax of 5.4 percent, bringing the marginal rate to 45 percent. States will have an increase in unfunded Medicaid mandate. Who is going to pay for that?

Mr. Speaker, seniors will see $500 billion, half a trillion dollars, removed from their access to care.

I urge my colleagues to vote ''no'' on Pelosi health care.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. DAVIS).

Mrs. DAVIS of California. Mr. Speaker, as chair of the Consumer Protection Committee in the California State Assembly, I worked hard to maintain and improve the protections and the rights that Americans deserve.

In the health care industry, which is really the most important of all sectors that deal with people's basic needs, millions of consumers are being taken advantage of on a daily basis and have few rights.

This bill changes that. It changes that and it puts us on the track of giving Americans and their families the peace of mind that they will never lose their health coverage.

I look forward to voting on this historic bill which puts consumers and puts Americans first.

Mr. KLINE of Minnesota. Mr. Speaker, I am very pleased to yield 1 minute to the distinguished gentleman from Oklahoma (Mr. COLE).

Mr. COLE. Mr. Speaker, I respect, like all Members do, everybody in this House, from the Speaker and the minority leader right down to the most junior Member. But the reality is, this isn't our House; this is the people's House. As I have listened to my friends on the other side, I have wondered, frankly, did you listen to what the people had to say in August in meeting after meeting after meeting? Have you taken the time to look at what they say in poll after poll after poll?

This is not an issue that has come on us suddenly. It is not a crisis. The American people have had a chance to study the issue, read the bill, and listen to the debate, and quite frankly, register an opinion. If we listen to them today, Mr. Speaker, we will follow their loud and insistent voice and vote ''no.''

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. FARR).

(Mr. FARR asked and was given permission to revise and extend his remarks.)

Mr. FARR. Mr. Speaker, I am ashamed on this great day of hope to hear so much fear, fear outside and fear inside. And I don't think they know fear. I know the fear of a woman carrying a baby dying because she has no access to health care. I saw that over and over again as a Peace Corps volunteer in Latin America.

Without health care, you can't start the day. You can't get up. You can't cope. You can't go to work. You need health care.

Combat that fear. Combat those fearmongers out there. Stand up for hope. Say ''yes'' to health care for all Americans. Vote ''yes'' for compassion. Vote ''yes'' for care. Vote ''yes'' for healing and health. Vote ''yes'' for my grandchildren.

Mr. FARR. Mr. Speaker, I rise in support of this historic bill and ask unanimous consent to revise and extend my remarks.

My first exposure to real poverty was as a Peace Corps volunteer in Medellin, Colombia. People there lived hard-scrabble existences, barely eking out subsistence-level lives.

My role as a Peace Corps volunteer was to help the community organize and petition its government for basic resources to improve the lives of the people. What I learned in that barrio is that unless people have shelter, unless they have food, and unless they have health care,—yes—health care, there can be no stability in the community and no confidence in the future. People need to have their health in order to cope and to be productive.

The lesson I learned in Colombia 45 years ago is still true today in the U.S.A., people in health care limbo can't focus on the future. They are too busy worrying about today.

History teaches us that America was built on neighbor helping neighbor. Colonists clung together in the New World and protected each other. Settlers out West never turned away a traveler. I am ashamed and amazed at the tone of debate today that would deny our fellow Americans access to health care coverage. That is not the American way. When did we become so selfish? At a time of historical hope why are we hearing so much about fear?

There is nothing to fear—tomorrow or a year from tomorrow you will still have you insurance policy, hospitals and doctors will be doing their jobs of caring and healing and for the first time the hope for health care for all will come true.

Tonight we are asked to make history—leadership is about getting results. To make just law we have to vote yes. I am proud to say ''yes'' to health care for all in America. ''Yes'' to compassion and care. ''Yes'' to healing and health. ''Yes'' to my grandchildren's future.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from South Carolina (Mr. INGLIS).

Mr. INGLIS. Mr. Speaker, I identify with the sentiments of the gentleman who just spoke. The only problem is if you look at Martin Feldstein's article yesterday in The Washington Post, what you see is that we are going to have another problem with the cost of this, that as folks have a problem with the cost shift continuing, we are actually going to make insurance more expensive, and actually people are going to lose coverage because they are going to decide to go bare until they get sick, then access the guaranteed issue, then cause premiums to rise, which will actually cause more people to be uninsured.

So the mandate here doesn't work because the penalties aren't high enough in the mandate to keep people from deciding to go bare until they are diagnosed with a problem.

The result will be that we actually end up with more people uninsured and higher premiums. The bill needs to be rethought. That is the kind of thing that we could develop in a collaborative process. That's not the process here. That's why we have this problem.

Mr. GEORGE MILLER of California. I yield to the gentleman from Massachusetts (Mr. OLVER) for the purpose of making a unanimous consent request.

(Mr. OLVER asked and was given permission to revise and extend his remarks.)

Mr. OLVER. Mr. Speaker, I rise in favor of H.R. 3962.

Mr. Speaker, we often hear that America has the best health care system in the world.

But, our health care system largely takes care of those who are lucky enough to be able to afford it.

In the past decade, the premiums charged by private health insurance companies have risen more than 75 percent while workers' wages have risen less than 25 percent.

To add insult to injury, the profits of the 10 largest health insurers have risen by 400 percent, and the salaries of their CEO's have tripled.

America now has 50 percent higher health care costs than the highest of the next 20 most industrialized nations.

Yet, Americans suffer the highest infant mortality rate among the G–7 countries. Our infant mortality rate is 50 percent above the average for the other 6 countries.

American life expectancies are more than 2 years lower than the average for the other 6 countries.

Clearly, we have the most expensive health care system in the world, but, equally clearly we don't have the best.

We can and must do better. We must reverse these trends.

This is our chance to fix a broken system.

I am proud to vote in favor of H.R. 3962, the Affordable Care for America Act.

For the 50 million Americans who still do not have health insurance, this historic legislation guarantees you will have good insurance—insurance that you can afford—which provides a sliding scale of credits available to families that earn up to 400 percent of the federal poverty standard, or $88,200 for a family of 4.

For those of us that are lucky enough to have health insurance, this legislation LL provides added stability by immediately banning lifetime caps and by 2013 eliminating pre-existing condition exclusions and annual caps on insurance coverage. You cannot be denied coverage.

For those who are concerned about losing or having to switch jobs—especially important in our current economy—this bill brings you added stability. You will always have access to affordable, quality health insurance.

For senior citizens on Medicare, H.R. 3962 protects your benefits. We know that seniors live on largely fixed incomes. As such, this bill puts money back into your pockets by reducing the donut hole immediately by $500 and immediately cuts the cost of brand name drugs in half for those who still find themselves in the hole. Furthermore, the donut hole is completely closed by 2019. The bill provides free Prevention and Wellness care and saves seniors money by reducing copayments and cost-sharing.

Finally, H.R. 3962 makes major investments in primary care so that we will have the critical infrastructure in place to efficiently combat the steady rise of deaths from preventable illness in this country. Between 1997 and 2002, when researchers compared preventable deaths—from diabetes, cancer, and heart disease amongst others—in 19 industrialized countries, the United States placed last. During those years alone, at least 75,000 men, women and children died because they lacked access to quality preventive care. Furthermore, H.R. 3962 makes new critical investments in training primary care providers, helping them with overwhelming student loan debt and paying them well for their service.

This is a historic time in our country's history. This bill makes the critical investments that are needed to turn our health care system around and provide the health care that our citizens deserve.

I am proud to cast my vote in favor of this monumental legislation.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, this debate in the House is part of a 97-year-old debate in America. It started with a Republican, Teddy Roosevelt, and continued with Democrats Harry Truman and Lyndon Johnson, then a Republican, Richard Nixon, who, while short on veracity, was great on policy and government. It continued through Bill Clinton, and now we are in a day when we have a chance to accomplish something worthwhile, something Daniel Webster tells us we should do while we are here in our generation and our time, to do something worthy of being remembered.

Theodore Roosevelt said, In this world the only thing supremely worth having is the opportunity, coupled with the capacity, to do well and worthily a piece of work, the doing of which is of vital consequence to the welfare of mankind.

I plan to take my voting card, along with hopefully at least 218 others, and do something that Teddy Roosevelt would see as proper, and provide health care for Americans.

The SPEAKER pro tempore. The gentleman from Minnesota and the gentleman from California each have 1 minute remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, let me just say that what we have before us here is a true loss for American families seeking quality health care and American workers seeking quality jobs. It is remarkable that our colleagues believe 2,000-plus pages of more red tape, more power in the hands of the super bureaucrat, more taxes will do anything other than make health care more costly and more complicated and kill more jobs in this country.

Why, when we have a 10.2 percent unemployment rate, the highest in a quarter century, would we ever want to pass legislation that will destroy millions of jobs? It defies logic. Why would we want to strip Medicare from the seniors who depend upon it? Why would we want to pile debt on our children and grandchildren? Why would we want to raise health care costs? Why would we want to raise taxes? I have yet to hear an answer to these questions.

This bill is not health care reform. The American people deserve better than this. We can do better than this. Let's make the right decision. Stop this Big Government takeover of health care and return to the table for real reform.

I yield back the balance of my time.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield to the gentleman from Pennsylvania for the purpose of a unanimous consent request.

(Mr. FATTAH asked and was given permission to revise and extend his remarks.)

Mr. FATTAH. Mr. Speaker, I support this bill, and I thank the chairman for yielding me the time.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota (Mr. OBERSTAR).

Mr. OBERSTAR. Mr. Speaker, I have advocated a national health care system as long as I have served in Congress. Today we take a decisive step toward that goal.

This is not a perfect bill but a good bill. The three committees have worked hard to address the needs of the people of my district, and my own concerns, regional disparities in Medicare reimbursement that penalize Minnesota health care providers, and ensuring taxpayer dollars are not used to fund abortion services.

Last summer I met with the Skare family in Cloquet. Their son, born with a congenital liver disease, required a liver transplant as a child. Today he is 20 years old. The family is buried under mountains of medical bills, despite having health insurance. They constantly have to fight the insurance providers to make them live up to their commitments. This bill will ensure that families like the Skares will not be held hostage to insurance companies. It will protect all Americans from being denied coverage due to pre-existing conditions.

Today, we keep faith with the American people. Today we ensure that quality, affordable health care is available to everyone. Support this bill.

Mr. OBERSTAR. Mr. Speaker, throughout my service in the House of Representatives, I have been a strong proponent for a national health care system to ensure that all Americans have access to affordable health care. Our current health care system is paradoxical. While our nation can take credit for having the best trained health care professionals and the most advanced medical devices, far too many Americans do not have access to essential health care. Our current health care system has failed this fundamental fairness principle, and as a result, health care has been rationed in this country with more than 46 million Americans without health insurance.

Long before the November 2008 elections and the beginning of this Congress, there has been near universal agreement that health care reform is necessary, and that the cost of inaction is unacceptable. Today represents an important opportunity to make health care more affordable and more accessible to more Americans.

Comprehensive health care reform involves more than just extending access to the uninsured. The explosion of health care costs has created tremendous challenges for the private sector that has hindered our ability to compete in the global marketplace. Additionally, it is imperative to constrain health care spending that consumes an unsustainable percentage of our federal budget. Health care reform is vital to the nation's economic recovery and fiscal responsibility.

I commend the leadership of the three committee chairman who have worked tirelessly to craft legislation to repair what is not working well and preserve what is working in our health care system. Thank you, CHARLIE RANGEL, HENRY WAXMAN, and GEORGE MILLER for your dedicated efforts to seize this historic opportunity and produce a sensible health care bill that builds upon and improves the employer-provided and private health insurance market.

I am very pleased that the House health care bill (H.R. 3962) includes many essential reforms that will improve health care. The health insurance provisions to ensure that Americans will not be denied coverage due to a pre-existing condition, the requirement for guaranteed issue and renewal, and the limit on out-of-pocket spending are much needed reforms that will make health insurance more available and affordable. For seniors, I strongly support the funding to close the donut hole in the Medicare Part D prescription drug program.

I am also delighted that H.R. 3962 contains provisions to address the historic disparities in Medicare reimbursement that have long penalized Minnesota and other high-quality, low-cost states. I greatly appreciate the dedicated work of my colleagues in the Quality Care Coalition (BETTY MCCOLLUM, RON KIND, BRUCE BRALEY, JAY INSLEE) to include language that will promote Medicare geographic equity. I believe that the requirement for the Secretary of Health and Human Services to implement the recommendations of an Institute of Medicine study will lead to Medicare payment reform that will reward value, not volume. This payment reform is one of my biggest priorities because in 2007, Medicare paid Minnesota hospitals $1 billion below the actual cost of care.

While I am very pleased that the House will have the opportunity to vote on amendment to ensure that taxpayer dollars are not spent for abortion, I am disappointed that several important amendments were not made in order. It was expected that the House would consider an amendment that would create a single-payer system for health care. While I continue to have great concerns about a single-payer system based on Medicare rates, I would have supported the single-payer amendment. I am disappointed that the Kucinich amendment which was supported in the committee mark-up to enable states to develop their own innovative state programs was stricken from the bill, and we do not have the opportunity to restore this language.

I am also disappointed, however, that the House health care bill does not contain a number of important policy reforms recommended by the National Rural Health Association (NRHA). The NRHA made more than ten specific recommendations regarding long-standing payment inequities that were unfortunately not addressed in this bill. I am especially troubled that several rural health improvements that were accepted in committee mark-up were not included in the updated House bill. It is essential that provisions to ensure rural representation on MedPac, and improvements in the 340B Drug Pricing program and the super rural ambulance reimbursement are restored in conference. I am also hopeful that the final conference report will include legislation that Minnesota's Senators and I have authored to provide Critical Access Hospital designation for a hospital in Cass County, Minnesota which I hope the Senate will include in their bill.

I strongly believe that Minnesota's leadership in health care reform should serve as a model for national reform. Minnesota is unique in requiring all health maintenance organizations (HMOs) to be nonprofit as a condition of licensure. Minnesota extended health care coverage to lower-income children long before the enactment of the federal SCHIP program, and Minnesota has done a better job in expanding access to care through its MinnesotaCare program than the rest of the nation. Minnesota has led the nation on integrated health systems to coordinate care, and a new partnership between Fairview Health and the Medica health insurance company that provides payment incentives to invest in health care rather than paying for ''sick care'' demonstrates Minnesota's continued leadership that is far ahead of national policymakers.

Even with the expected improvement in Medicare reimbursement that will benefit Minnesota, I am concerned in many respects that Minnesota is picking up the tab to pay for national health reform. While I understand and support the need to reduce the excessive payments in the Medicare Advantage program, it is far easier for high-cost states to absorb a 14 percent cut than for Minnesota which receives significantly less in Medicare Advantage payments. I am also concerned with the addition of a tax on medical devices that will negatively impact Minnesota's important medical device industry, as well as changes in the second generation biofuel producer credit that will preclude ''black liquor'' from eligibility for this biofuel credit that will impact the wood product industry in Minnesota. I will strongly encourage modifications in the financing in the final version to ensure fairness for Minnesota.

During the thorough discussion and debate regarding health care this year, I have greatly appreciated the opportunity to visit with constituents in Minnesota and in Washington. From seniors and health care providers to organized labor, the small business community and the faith community, I have gained valuable insights and recommendations to improve this legislation.

While I recognize and understand there are still many issues that need to be addressed, I am prepared to support this legislation today to move this necessary process forward.

Mrs. LOWEY. Mr. Speaker, I rise in support of the Affordable Healthcare for America Act.

Over the last eight months, I have communicated with tens of thousands of my constituents in Westchester and Rockland Counties in meetings, conference calls, round-tables, telephone town halls, and neighborhood office hours.

Among people from of all walks of life—small business owners, doctors, patient advocates, and seniors—one constant is the passion which most agree on the need for health care reform despite different opinions on how best to achieve reform.

Since 2000, personal premiums have more than doubled.

Since 1987, the cost of the average family health insurance policy has risen from 7 percent of the median family income to 17 percent.

In 2007, 60 percent of all U.S. bankruptcies were due to medical costs.

The U.S. is on track to spend nearly $33 trillion on health care over the next decade.

The financial security of our families, businesses, and our overall economy depends on meaningful health care reform.

That's why I will support this bill today to:

Provide health coverage to approximately 36 million Americans, including 39,000 residents in my congressional district.

Help small businesses who are struggling to provide coverage to their employees while exempting 86 percent of the smallest businesses from the requirement to do so.

Ensure that reform is fully paid for while exempting 99.7 percent of all American households from paying a health care surcharge.

Guarantee additional protections to those who have insurance, including ending discrimination for pre-existing conditions; limiting annual out-of-pocket costs; and preventing health insurance companies from dropping your coverage if you become sick.

Improve and strengthen Medicare.

Now, this bill is not perfect. I am deeply disappointed that the House approved language which puts new restrictions on women's access to abortion coverage in the private health insurance market even when they would pay premiums with their own money.

If we want to reduce abortions we should give millions of women health coverage so they can get regular reproductive care, contraceptives to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.

Despite this damaging provision, we must move forward in improving health coverage for those who have it, providing coverage for those who don't, and controlling costs throughout the system.

I urge my colleagues to support this legislation.

Mr. LOEBSACK Mr. Speaker, this August and September I held 16 town halls across the 2nd District of Iowa. I heard from countless Iowans about the need to change the current health care system. Though some disagreed with provisions in the original House proposal, almost everyone agreed that the fact that a family in Iowa pays an extra $1,100 per year in premiums to support a broken system was unacceptable. So I am proud to be a part of a Congress that decided the status quo is no longer acceptable. Iowa families want stable health care coverage that can't be taken away, they want greater choices, and they want to know that if they get sick they won't be forced into bankruptcy. The Affordable Health Care for America Act answers these calls to action and I'm proud to support a bill that is good for Iowans.

This legislation keeps what works in the current system and fixes what doesn't. If you like your current health insurance and you like your doctors you can keep them. If you don't have health insurance, you will be able to acquire it. In fact, some of the greatest changes from the original House proposal to the bill we are considering today are the immediate reforms. We aren't saying wait for coverage, we

are saying the status quo is not fair and we will no longer tolerate it starting right now.

There will be help for hardworking families now. The revised bill immediately creates an insurance program with financial assistance for those who have been uninsured or denied coverage because of pre-existing conditions, and fills the gap until the Health Insurance Exchange is up and running. The bill immediately prohibits health insurance companies from rescinding coverage. If you find out you are sick one day, you don't have to worry that your health insurance will be taken away the next.

The revised legislation also immediately prohibits health insurers from utilizing lifetime limits on benefits, and extends COBRA eligibility to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running. America's Affordable Health Care for America Act also makes immediate changes to improve the health and well being of our seniors. The legislation begins closing the Medicare Part D Donut Hole in January. There will also be an immediate 50 percent discount for brand name drugs in the donut hole.

In addition to the immediate benefits, this legislation takes a comprehensive approach to long-term reform. I am a native Iowan, and since I came to Congress I have been committed to fixing the broken Medicare payment system. The geographic disparities in the system have caused problems not only for providers in my District, but also for the patients.

I have always been proud of how hospitals in my District have achieved so much under the constraints of the current Medicare payment system. With some of the lowest reimbursement rates in the country, they provide some of the highest quality care. However, the current system is broken and now I'm proud to say that the Affordable Health Care for America Act reforms Medicare payments so that they are based on the quality of services rather than the quantity of services. This fix benefits not just Iowa, but all of America.

I also want to mention another provision with direct benefit to Iowa in this legislation. According to a 2008 Institute of Medicine report, Retooling for an Aging America: Building the Health Care Workforce, in the near future, the nation will be aging dramatically, leading to an increase of older adults from 12 percent of the U.S. population in 2005 to almost 20 percent by 2030.

As the population ages, their health care needs will increase, and they will need additional supports. In the same report, it's stated that meeting the demand that is expected in coming years will require expansion of the roles of many members of the health care workforce, including technicians, direct-care workers and informal caregivers, all of whom already play significant roles in the care of older adults.

I was very pleased to have language included in this bill that takes much needed steps towards meeting these workforce demands, as well as other projected long-term health needs. The provision encourages the identification, promotion, and implementation of investments in the long-term care workforce and assists States in developing comprehensive state workforce development plans.

It also creates a Workforce Advisory Panel which will identify core competencies for long-term care workers and recommends training curricula and resources for these workers. The bill also creates a demonstration project to evaluate the Panel's recommendations. In addition, this legislation improves assistance to family and informal caregivers, and improves the dissemination of information to seniors regarding their long-term care health insurance options.

In a recent guest column in the Des Moines Register, John Hale from the Iowa Caregivers Association, highlighted the efforts that Iowa has already undertaken on long-term care workforce shortages and spoke about the national need to address these issues. Mr. Hale stated that, ''Access to coverage does not equal access to care.'' I could not agree more.

Federal support is essential in helping all states continue to look at both workforce shortages and the core competencies that should be required of those in the field. I have said many times in the past weeks and months that quality health care is the key to patient outcomes. I am glad this legislation takes much needed steps to support our long-term care workforce.

There are many more important provisions in this legislation and in the coming days, weeks, and months I look forward to discussing this bill, and what it does for Iowans, with my constituents. I look forward to voting for the Affordable Health Care for America Act, and abolishing the status quo.

Mr. WESTMORELAND. Mr. Speaker, on this bill the Congress is scheduled to vote on today will cost more than $1.3 trillion over the life of the bill.

It'll expand entitlement spending, it'll raise taxes on small business payrolls, it'll cost jobs by mandating coverage that some businesses can't afford, it'll put government in between the doctor and the patient, and it'll cut Medicare funding. By expanding Medicaid eligibility, the legislation puts new burdens on states that already are struggling to pay their bills. The states share the cost of the Medicaid program, and this could cost my home state $2 billion to $4 billion over the next 10 years. That's a huge share of Georgia's state budget, and it's a cost we simply can't bear.

But, luckily, there is a better way. Republicans are providing that alternative, although the Democrats continue to insist we're not offering ideas. We are. They just don't want Americans to know it.

Ms. SPEIER. Mr. Speaker, today, I look forward to keeping my promise to the voters and taxpayers who sent me to Congress by casting a vote for a historic health care reform bill that has been sixty years in the making.

Still, with any effort as far-reaching as reforming health care, Americans are right to ask: ''What's in it for me?''

Well, I'll tell you.

If you are a woman, this bill has plenty for you. You know, far too well, that our fight for equality is not limited to the board room. We must fight for our rights in every line of fine print in every insurance contract. The fact is that women's health care premiums cost, on average, more than 145 percent of the price of a similar man's policy. Even then, women are more likely to be denied coverage for a pre-existing condition, including for things as common as getting pregnant (or the inability to get pregnant) having a c-section, even being a survivor of domestic violence. With the passage of this health care reform bill, these practices will be tossed on the ash-heap of history atop corsets, chastity belts and other limitation on women's rights and equality. In fact, with this bill, America's mothers, wives and sisters will finally enjoy the same health care coverage that their fathers, sons and brothers have.

If you are an American of retirement age, this health care reform legislation contains provisions that ensure high quality, effective health care throughout your retirement years. We have heard your frustrated calls to end the ill-conceived Medicare Part D donut hole and responded by immediately reducing the hole by $500 and, by 2019, getting rid of it once and for all. The bill also cuts in half the cost of name-brand drugs. No older American should ever have to decide between purchasing food or the life-saving medicine prescribed by their doctor.

When Congress voted for Medicare nearly 45 years ago, this House promised seniors quality, affordable health care in their retirement. They did this despite a future president, Ronald Reagan, decrying Medicare as socialism—sound familiar?

Well, by cutting waste, fraud and abuse, eliminating the out-of-pocket payments for preventative care and banning overpayments, this Congress is making good on that promise and extending the Medicare trust for future generations.

If you are one of the 14,000 Americans who lose their health insurance coverage every day, this bill offers comfort and hope when you are most in need. Just last night during a telephone town hall a constituent told me how, at 55 years old, she lost her job and her health coverage. She wonders if, even after the economy recovers, she will be able to get a job—at her age—that provides health care. Today, when workers like her lose their job and their coverage, they are forced into the snake pit that is the individual insurance market where insurance company practices like denying coverage because of a preexisting condition are common. Fortunately this practice, along with dropping customers once they fall ill, has been outlawed in this bill. Also, while the health care exchange—which will provide access to affordable, quality health care—is being set up, a high-risk insurance pool will be available so that you have coverage in the meantime.

For the majority of Americans who have health insurance through their employer, you get the best news of all. I don't have to tell you that, since 2000, employer-sponsored health insurance premiums have more than doubled. Your employer's real health care costs have risen at a rate that is three times faster than wage increases and business profits. This is, quite simply, unsustainable. If we took a page from the opposition party and did nothing, the cost of employer-sponsored family health insurance plans would reach $24,000 in less than ten years. This same price spike would result in families spending 45% of their income on health insurance. Also, the insurance exchange will allow you or your employer to purchase coverage from health plans that meet guaranteed benefit levels, cap annual out-of-pocket spending and end annual and lifetime benefit limits. There will also be a public option that is completely self-supported by premiums.

This is not a decision that has been made in haste. No issue has been studied, scrutinized and debated more than health care reform. And, like every time in our nation's history when sweeping changes are proposed—

whether it be Social Security, Medicare, civil rights, women's suffrage or the creation of the Veterans Administration—emotions have run high in this debate and there has been no shortage of opinions on every side.

The bill we are set to vote on is a compromise between many different points of view. It is the result of the most exhaustive and transparent review process of any bill in our nation's history, with hundreds of hours of bipartisan committee meetings being devoted to it and the final text being posted on-line more than three days prior to a vote being taken. Compare that to the Republicans Medicare Part D bill in 2003 which was forced to a vote just hours after the bill was printed.

It will be a proud day for this Congresswoman—and for America—when Congress finally sets our nation on a path toward greater access, greater equality and greater accountability and competition in our health care system.

This is what my constituents sent me here to do. And I am happy to oblige.

Mr. LATHAM. Mr. Speaker, everyone agrees that health care costs too much in this country, but we can fix the problem without a trillion-dollar government takeover of health care. The bill before us now takes us in the wrong direction. It slashes Medicare and pins small businesses with job-killing taxes and mandates, at a time when our economy is struggling and unemployment is over 10 percent.

More federal controls on the content of insurance policies have nothing to do with covering the uninsured and will increase costs for most families rather than decrease them. If you have coverage through an employer, your premiums will go up. If you have an individual policy, you will have to switch to a federal exchange plan in 2013 or face a fine or, possibly, jail time for not having federally qualifying coverage that you may not be able to afford. Younger people in particular could see their premiums increase by more than 70 percent.

Instead of taking the approach we are taking today, we should implement commonsense reforms that focus on covering the uninsured and lowering health care costs. We must ensure those with pre-existing conditions get quality coverage. We can lower costs by requiring insurance companies to compete nationwide, and we can clamp down on frivolous malpractice lawsuits. Most of the uninsured work for small businesses that cannot afford health insurance for their employees, and we should allow small businesses to pool together for lower premiums. Such reforms have bipartisan support and could be enacted immediately to provide relief for millions of Americans struggling with health insurance costs.

On another note, this bill contains no guarantee that Iowa's Medicare reimbursement rates—which are among the lowest in the country—will see any sort of increase. At the same time, this bill specifically increases Medicare payments in 14 counties in California, the home state of Rep. HENRY WAXMAN, one of this bill's main authors. This may be viewed as reform by some, but it is certainly uneven reform for those counties in our districts that do not benefit from such increases.

Throughout the summer and early fall, more than 12,400 residents of Iowa's 4th Congressional District responded to my health care survey. A majority were unsatisfied with the state of health care in America, and rightly so. More than 70 percent of respondents ranked cost as the most pressing concern regarding health care in the United States, followed by access at 14.6 percent and quality at 8.4 percent. However, 86 percent described the quality of their personal health care as either ''excellent'' or ''good'' and they do not want to be forced to give up coverage they are satisfied with. Some 65 percent said the government should play ''no role'' or a ''minor role'' in determining health insurance options for Americans. My constituents support common sense solutions. Approximately 64 percent support doing away with exclusions for preexisting conditions, 75 percent thought people should be allowed to purchase health insurance across state lines, and 69 percent support small business health plans.

To sum it all up, this bill is clearly not what is advertised by its supporters and it is not what my constituents want. We need to go back to the drawing board and produce a bill with common-sense solutions that the vast majority of Americans support.

Mr. CASSIDY. Mr. Speaker, I have spent 20 years caring for the uninsured in Louisiana's public hospital system.

Skyrocketing costs put quality care out of reach for too many Americans, and I appreciate that everyone agrees the status quo is unacceptable.

All agree on the goals of reform: lower costs and expand access to quality care.

Unfortunately, this bill does not achieve our goals.

The Congressional Budget Office says it raises costs.

Without lowering costs, access or quality will suffer.

Its effects will be radical, but this is not a radical bill.

It turns insurance bureaucrats into federal bureaucrats.

There's no innovation, just nationalization.

Real reform would revolutionize health care.

Real reform would give patients, not bureaucrats, the power.

Unless patients are empowered with control over health care dollars and decisions, costs will not be lowered and access will not be expanded without sacrificing quality.

The road to real health reform begins with stopping this bill today.

I urge my colleagues to join me in this effort.

Mr. PRICE of North Carolina. Mr. Speaker, as the House of Representatives approaches this historic vote, my mind travels back to the formative years when I first became engaged in politics, and also to hundreds of meetings I have had with constituents since the citizens of North Carolina's Fourth district first sent me to Congress.

I came of age as the civil rights movement of the late '50s and early '60s swept across the country. It shaped and transformed my social, religious, and political views. I remember the culminating moment in 1964 when, as a Senate staff member, I crowded into the gallery and witnessed the dramatic passage of the Civil Rights Act of 1964.

That momentous bill marked an expansion of democracy and of access to opportunity for millions of Americans. Today's vote is also momentous, and it also marks an expansion of democracy's promise. Today we resolve that never again will American citizens be denied access to health insurance, and that one of life's most basic needs—health care—will be available to all of our people.

As I think back on my years of congressional service, I remember meetings with parents terrified at the prospect that their children with serious illnesses would not be able to obtain coverage when they reach adulthood. I remember maddening stories of families coping with illness while simultaneously fighting with insurance companies. I remember young adults unable to buy affordable insurance, often because of allergies or other minor conditions. I remember retirees not yet eligible for Medicare being quoted rates of thousands per month because of their health history.

Mr. Speaker, we have all heard these stories. They are unworthy of our country. And today we have the opportunity to bring such hardship and heartache to an end. The American people deserve a health care system that works for them—one that provides access to stable coverage, quality care, and affordable premiums and copayments. The legislation before us today will correct the failures of the American health care system without compromising its many strengths or adding to the budget deficit.

If you have coverage at work, you'll be able to keep it—but the loss of a job will no longer mean the loss of affordable coverage. And your insurance company will no longer be able to impose lifetime benefit limits; discriminate on the basis of age, gender, or pre-existing conditions; or cancel your policy if you get sick.

If you have coverage through Medicare, you'll have more benefits and lower out-of-pocket costs, including no more copayments for preventive and many diagnostic services, and a 50 percent discount on your brand-name prescriptions, and a progressive closing of the gap in coverage known as the ''doughnut hole.''

If you don't have coverage at all, you'll be able to buy it on the National Health Exchange at the same affordable group rates that big companies have always been able to negotiate for their employees. And you'll have more than one choice, so that companies will have to compete for your business instead of the other way around.

Landmark reforms—Social Security, Medicare, Medicaid—these things do not come easily. We were sent to Congress this year to do what is difficult. Despite the efforts of some shrill voices, we are on the verge of overcoming the special interests that halted reform more than a decade ago, to deliver on landmark legislation that will make a positive difference in the life of every American. It is an historical moment, an essential investment in our nation's long-term fiscal and economic well-being, and it's long overdue. I urge my colleagues to vote yes on the Affordable Health Care for America Act.

Mr. BACA. Mr. Speaker, today is a historic day for all of us.

As Members of Congress, it is our duty to pass real healthcare reform this year.

The American people are suffering.

47 million people lack even the most basic care, and for those lucky to have insurance—their premiums have more than doubled over the last 10 years.

Perhaps no state is in greater need of this reform than my home state of California.

217 thousand people in my Congressional District go everyday without insurance.

And for California as a whole—we have 13 million uninsured residents.

The people of California, and people across the United States need health care reform that: ends discrimination based on pre-existing conditions; ends dropped healthcare coverage because you get sick; ends co-pays for preventative care; and ends skyrocketing costs for individuals and families.

The Republican alternative does none of these things.

It simply keeps the status quo! It does nothing to provide quality, affordable health care to the American people.

The 217,000 people living in my District without insurance cannot afford inaction any longer.

The 13 million people in California without insurance cannot live with the status quo.

The 15 hundred families in my District who went bankrupt because of health costs cannot afford the status quo.

Now is our opportunity to make history—and to move America forward.

We must not be short-sighted and focus only on politics and polls.

As a Christian—my faith teaches me we must love and care for our fellow man, as if they were our brother or sister.

I know that fixing our broken health care system is not just an economic issue—it is also a humanitarian and a moral issue.

I am especially pleased that today's bill includes the Indian Health Care Improvement Act.

As a Member of the House Native American Caucus and the Natural Resources Committee—I have been a strong supporter of ending the health disparities that exist on our reservations.

I will close my statement by again stressing the importance of this historic moment.

We passed Social Security in 1935. We passed Medicare in 1965.

I urge my colleagues to stand with the American people and pass legislation in 2009 that will make quality, affordable health care a right for all Americans.

Mr. LANCE. Mr. Speaker, this evening members of the U.S. House of Representatives are being asked to vote on legislation that dramatically revamps our Nation's health care system.

This 2,000-plus page, $1.3 trillion Democratic health care proposal is a measure that raises individual and business taxes and reduces funding for Medicare.

H.R. 3962 increases spending by more than $1 trillion at a time when our levels of debt and deficits are at all-time highs.

The bill imposes a 5.4 percent ''surtax'' on thousands of individuals and families in my congressional district during an economic recession and when New Jerseyeans are paying some of the highest federal, state and local property taxes in the country.

The health care bill levies at 2.5 percent tax on the Garden State's medical device industry that employs more than 300,000 in New Jersey alone at a time when New Jersey's unemployment rate is nearly 10 percent.

The measure ignores common-sense malpractice reforms while cutting Medicare by nearly $500 billion leading the Medical Society of New Jersey and its doctors and medical professionals to come out in opposition to H.R. 3962.

In short, this bill, If signed into law, will be harmful to New Jersey's taxpayers, seniors and businesses. As such, I rise in strong opposition to this measure.

But make no mistake—I support health care reform.

Like the majority of my colleagues I strongly support health care reform. But not the reform we will be voting on this evening.

I stand in support of common sense steps to broaden health care access and responsible solutions that address the rising cost of health care.

I believe reform ought to include portability—allowing people to keep their health insurance whether they change jobs or move to a different state. And no one should be denied coverage for preexisting conditions.

Yet the call for common sense health care reform should be one that our Nation can afford.

The Republican substitute offered by House Republican Leader JOHN BOEHNER is a fiscally responsible alternative health care reform measure that reduces costs and expands insurance coverage without raising taxes, rationing care or putting the government between patient and doctor.

The Republican reform bill includes medical liability reform that will seek to end junk lawsuits that force doctors to practice defensive medicine driving up health care costs.

The GOP alternative will allow families and businesses buy health insurance across state lines while also allowing individuals, small businesses and trade associations to pool together and purchase health insurance at lower prices.

It levies no taxes on New Jersey's medical device industry and includes important safety provisions concerning innovative biologic drugs by requiring research and clinical trials before the Food and Drug Administration can approve generic biologics.

To maximize safety, I believe that research and those clinical trials should be conducted within the United States. By creating this process for approval of innovative biologic drugs we protect the health and safety of patients, lower health care costs and provide adequate incentives for innovation to ensure that New Jersey continues to be the ''Medicine Chest of the World.''

These are ideas that have strong, bipartisan support but most are absent from the Democrats' new reform legislation.

Instead of focusing on fiscally responsible reforms that have bipartisan support, the Democratic Leadership has chosen a path that ignores good ideas from the Republican side of the aisle.

The Republican substitute is the only health care reform measure that improves what is working in our health care system and fixes what is broken in a fiscally responsible manner without raising taxes or increasing our ever-growing debt and deficit.

Mr. WILSON of South Carolina. Mr. Speaker, I have criticized many of the provisions of this bill (H.R. 3962) and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this weeks devastating news that unemployment has reached 10.2 percent it is critical that we preserve jobs in the United States. While the innovator's have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should occur in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. SMITH of Texas. Mr. Speaker, although the Democratic Leadership has had several months to address the concerns voiced by countless Americans, the latest health care reform bill is no better than the last.

I support health care reform; however, this bill goes far beyond fixing the problems we all know need to be addressed and it fails to enact true health care reform.

Skyrocketing costs have crept into our health care system, creating uncertainty about the future of health care for employers, working Americans, and the uninsured. Americans need more, not fewer, choices for something as important and personal as health care.

Americans are concerned with cost, choice, quality and access of health care and Congress should work to address these concerns. Any legislation considered should attempt to make our health care system more accountable and accessible to patients.

This legislation expands coverage with a government takeover of the health care industry funded by new taxes and massive cuts to Medicare.

The nonpartisan Congressional Budget Office and Joint Committee on Taxation estimate that H.R. 3962 would require over $550 billion in new taxes on individuals and small businesses.

CBO also estimates that this legislation will lead to $33 billion in penalties for uninsured

individuals and $135 billion in penalties for employers under the government mandate or ''pay or play'' requirements.

Raising income taxes on hard-working Americans and threatening small businesses with penalties to fund a government takeover of health care is a terrible prescription for a troubled economy.

In order to pay for this government takeover of health care, Democrats also have proposed cutting more than $500 billion in Medicare spending. The plan also includes an expansion of Medicaid that will cost cash-strapped States $34 billion over the next 10 years.

I believe Congress should pursue reform in terms of costs and access, but the legislation advanced by Democratic leaders is equal parts faulty premise and flawed logic. Their legislation will increase health care spending, limit choice, and cut Medicare benefits.

The current health care proposal being considered by Congress will lead to higher costs, rationing of care, higher taxes on families and small businesses, elimination of jobs through punitive taxes on small businesses, granting of unchecked power to a new ''health care choices commissioner,'' elimination of choices for patients, tax-payer funded abortions and a government panel placed between doctors and patients.

Americans deserve the freedom to choose the type of health care that is best for them and their families.

During his campaign, then-Senator Obama promised that he would ''have all the negotiations around a big table'' and ''televised on C–SPAN'' to ''allow people to stay involved in this process.'' Yet the negotiations and decisionmaking process have taken place behind closed doors with the media and American people shut out.

That is why the bill lacks bipartisan support. In fact, there is bipartisan opposition to the House Democrats' government take-over.

Rather than increasing taxes and rationing care, the President needs to address medical liability reform, which is one of the biggest sources of waste and added cost.

Frivolous lawsuits force physicians to practice defensive medicine and carry expensive malpractice insurance, the cost of which is passed on to patients. Uncapped lawsuit awards paid by insurance companies also get passed on to patients as higher premiums.

It is a disservice to the American people that this legislation fails to include the legal reforms that are necessary to make any expansion of health care coverage financially sound.

Unlimited lawsuits enrich trial lawyers while increasing the cost of health care for everyone. Unfortunately, we now know that opposition by trial lawyers is the reason tort reform has been excluded from all the Democrats' health care proposals, including the one we will be voting on today. Former Democratic National Committee Chairman Howard Dean said the following publicly at a recent town hall meeting: ''[T]he reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers . . . and that is the plain and simple truth.''

That political opposition, which Governor Dean admitted is not based on the merits but on raw self-interest, flies in the face of the facts.

The CBO estimates that enacting tort reforms nationwide would result in a reduction of medical malpractice insurance rates by 25 percent to 30 percent. And according to the Government Accountability Office, rising litigation awards are responsible for skyrocketing medical professional liability premiums.

Lower premiums mean Americans will pay less to have better health care.

The President of the American Medical Association said ''If the [health care] bill doesn't have medical liability reform in it, then we don't see how it is going to be successful in controlling costs.''

And the President's own doctor of over two decades supports tort reform. He said regretfully that ''I once briefly talked to [the President] about malpractice, and he took the lawyers' position.''

In the handful of States that have enacted tort reform, health care costs have fallen, and the availability of medical care has expanded. In my home State of Texas, premiums fell by 30 percent, and more than 14,000 doctors returned or set up new practices in the state.

To give just one example, a charitable hospital group in Texas that serves the poor and underserved reported that since Texas enacted tort reform, its legal costs have gone from $153 million per year to just $2.3 million last year.

Doctors are so concerned about frivolous lawsuits that they order unnecessary—and expensive—tests and procedures that are of no benefit to the patient.

HHS estimates the national cost of defensive medicine is more than $60 billion. The Congressional Budget Office just issued a report that concludes it costs $54 billion. The costs of litigation and defensive medicine are then passed off to the patient in the price of health care.

If tort reform were enacted, trial lawyers would stand to lose one of their primary sources of income: medical malpractice suits, which are often just a form of legalized extortion. But all Americans would gain, and tens of billions of dollars would suddenly be freed up and could be used to help provide health insurance to the uninsured.

Regrettably, the Democrats' health care bill not only fails to contain any of the tort reforms the CBO concluded would save at least $54 billion in health care costs, but also contains a provision that bribes States with Federal taxpayer dollars not to enact such reforms in the future. It explicitly prohibits tort reform ''demonstration project'' funds from going to States that put limits on damages or attorneys' fees.

Section 2531 of the Democrats' bill states that ''the Secretary [of HHS] shall make an incentive payment . . . to each State that has an alternative medical liability law in compliance with this section,'' but then goes on to say a state can take advantage of such funds only if ''the law does not limit attorneys'' fees or impose caps on damages,'' which are exactly the tort reforms the CBO concluded yield real health care costs savings.

That is not only a blow to State reform efforts. It is a federally funded bribe discouraging states from enacting real reform and a giant bailout for trial lawyers.

H.R. 3962 also contains two antitrust provisions that are within the House Judiciary Committee's jurisdiction: Sec. 262, which repeals the McCarran-Ferguson Act for health and medical malpractice insurers, and Sec. 2573, which codifies a ban on settlements between name brand and generic pharmaceutical manufacturers in the context of Hatch-Waxman litigation. Neither provision was given due consideration in the Judiciary Committee, and their unintended consequences could have significant negative impacts on the cost and availability' of both insurance and medications.

My basic concerns with Sec. 262 are its breadth, the possible unintended consequences, and the fact that the provision will do no good and may do much harm. For more than 60 years, the States have regulated the business of insurance and built a record that provides guidance about permissible activity. By inviting Federal intervention, this bill creates a dual regulatory system that only confuses the health insurance and medical malpractice industry.

The bill presents a wholesale repeal of McCarran-Ferguson for health insurers and medical malpractice insurers. Further, the protections for information gathering by a State insurance commission or other State regulatory entity that were included in the similar bill (H.R. 3596) reported by the Judiciary Committee over my opposition have been completely eliminated from the legislation.

The uncertainty caused by this provision threatens small and large insurers alike, but the smaller ones that depend on sharing information, under oversight by State regulators, are most at risk. Thus the bill threatens to reduce competition among health and medical malpractice insurers. With no demonstrable benefits and many potential adverse effects, Sec. 262 should not have been included in the bill.

Section 2573 raises different concerns. When a generic drug manufacturer files an Abbreviated New Drug Application under the Hatch-Waxman Act with the Food and Drug Administration, it indicates its intention to infringe on a brand manufacturer's patent. This means that the generic company is trying to enter into the brand manufacturer's drug market before the branded pharmaceutical's existing patent has expired. This notice usually results in a lawsuit by the brand company that leads to a settlement about the date on which the generic manufacturer can begin selling a generic version of the branded company's drug. This is nothing new. Most cases in the United States, whether civil or criminal, antitrust or patent, settle. The reasons for this are simple: litigation is expensive and its outcomes are uncertain.

The supposed problem is when a settlement in the Hatch-Waxman context involves a payment in lieu of or in addition to an agreement on the date of entry into the market by the generic manufacturer. Such payments are said to frustrate the intent of Hatch-Waxman by allowing the brand company to ''pay to delay'' entry of the generic competitor.

The proposed solution to this problem, incorporated in Sec. 2573, goes too far. The bill calls for a ban on all Hatch-Waxman settlements that feature any consideration, such as cash or an exchange of patents, in addition to the date of entry. Such a ban dramatically reduces the ability of companies to settle these cases. After all, if the parties could not agree on date of entry, then they would effectively be forced to litigate the case to the bitter end. This means that, in some cases, a settlement would have resulted in generic entry into that particular drug market much earlier than if the brand company wins its patent suit.

I fear this ban will itself frustrate the intent of Hatch-Waxman by limiting the incentives for

generics to challenge these patents and for brand companies to innovate.

The best way to reach the appropriate balance is through a case-by-case analysis by a neutral third party of the competitive effects of these settlements using the rule of reason. This, in essence, is the conclusion that the majority of the Courts of Appeals, including the Second, Eleventh, and DC Circuits, have reached in these cases, and we should uphold the judgment of these courts.

The only saving grace of Sec. 2573 is that it creates a cause of action separate and apart from the antitrust laws and will not affect how those laws are interpreted in the future. This also means that the provision, as written, did not come before the Judiciary Committee, even though it remains, at heart, a competition issue. By keeping the Judiciary Committee from considering this legislation, we are eliminating the incentives for drug invention and generic competition that have served American consumers so well. Innovative new drugs, after all, are created in the laboratory, not the courtroom.

Sec. 1640 of the bill also contains a provision that allows the Department of Health and Human Services to issue administrative subpoenas to insurance companies during investigations of decisions to exclude benefits. The standard for issuing an administrative subpoena under the bill is extremely low. The information sought must simply ''relate to'' the matter under investigation.

It is highly ironic that we are considering this bill with this administrative subpoena language during the same week the Judiciary Committee approved the Democrats' revision of the FBI's authority to issue National Security Letters, which are the functional equivalent of administrative subpoenas used in foreign intelligence and terrorism investigations.

The Democrats' bill reported this week by the Judiciary Committee replaces the current ''relevance'' standard for issuing a National Security Letter with a heightened standard, requiring the FBI to show ''specific and articulable facts'' in order to seek particular information using a National Security Letter. House Democrats want to make it easier for the government to investigate insurance companies than to investigate terrorists plotting to kill Americans.

In the end, this 1,990-page bill will raise premiums and health care costs on all Americans. It imposes mandates and new taxes on the middle class and small businesses. It fails to address tort reform and it dumps a huge unfunded expansion of Medicaid on the states. Combined with budget gimmicks to hide $245 billion in costs and massive cuts to senior benefits, this is simply bad medicine.

Mr. MORAN of Kansas. Mr. Speaker, after reviewing H.R. 3962, the Affordable Health Care for America Act, listening to the concerns of Kansans, and visiting Kansas hospitals to speak with doctors, nurses, patients, and administrators, I have concluded that this bill will be harmful to Kansas and I strongly oppose it. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to patients without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton, EIB amendment in the House Energy and Commerce Committee.

Creating a pathway for new products that does not destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time providing a safe and effective way to bring competition to benefit patients and encourage treatments, is a necessary objective. New biosimilars have the potential to fundamentally change the course of many diseases. We need to promote patient safety and ensure incentives to encourage the continued development of a critical weapon to fight diseases such as Alzheimer's, Parkinson's and cancer. I wish we could remove these specific provisions from H.R. 3962 and consider them separately because it would most likely pass with the kind of overwhelming bipartisan support.

However, these provisions are only the first step in a long path to the marketing of these new biosimilar products. New research and clinical testing will have to occur and the FDA will implement regulations that will ensure this research is done safely and effectively. Biopharmaceuticals represent a tremendous growth opportunity for our burgeoning bioscience industry in Kansas, and we need to work to see that new biotechnology products continue to reach patients and medical professionals.

As this new biosimilar market develops in the United States, we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into determining whether these products are interchangeable with the innovator's products. Testing and research on these interchangeable biosimilar products should occur in this country to ensure that it is done properly and safely and to benefit our patients and our economy.

Ms. GRANGER. Mr. Speaker, I have criticized the majority of the provisions in H.R. 3962, the Affordable Health Care for America Act, and I will vote against it. However, I am pleased that H.R. 3962, as well as the Republican Substitute Amendment that I support, both include language relating to biosimilar products.

The provisions related to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted in a bipartisan vote for the Eshoo-Inslee-Barton amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this bill so that I could vote for it on its own. I believe that if this provision was considered on its own it would pass the House of Representatives with bipartisan support.

The biosimilar provisions in this bill are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively.

One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. With this week's news that unemployment has reached 10.2 percent, it is critical that we preserve jobs in the United States. Testing and research on these generic biosimilars should take place in the United States to ensure that it is done properly and safely while benefitting our economy.

Innovative biotechnology companies have created jobs here in the United States and we must continue to support them.

Mr. PAYNE. Mr. Speaker, I an others have spoken at length on the ways that this bill will improve health care for all of our constituents. Another significant benefit of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of Americans in this country who currently have no insurance will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and technicians for their care, while reducing overall healthcare costs because they will not need much more expensive hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will be a win/win for Americans: high quality health care at an affordable price.

Third, this bill will create high quality research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reducing costly invasive procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchangeable with an innovator's product. This research will create high quality and high paying jobs and it is imperative that we keep this research and these jobs in this country.

We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

I do not look at this bill as one of cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country while at the same time improving the lives of ALL Americans. This bill will improve health care, create jobs and grow our economy.

Mr. TERRY. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country.

As this new market launches in the United States, we need to ensure that we foster innovation and ensure the safety of any new product brought to the market.

Ms. CLARKE. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this legislation because it eliminates gender rating that allows young women to be charged 45% more than men for identical coverage.

Mr. POE of Texas. Mr. Speaker, H.R. 3962 forces businesses and individuals to purchase health insurance. It raises at least two constitutional issues. Congress should never pass an unconstitutional bill, and I will vote against H.R. 3962.

The Constitution doesn't give the Federal Government direct authority to compel the purchase of health insurance. The Supreme Court would once again have to come in and by judicial edict give the government the intrusive power to do what it obviously cannot do now: stretch the meaning of the Commerce Clause.

Can the Federal Government force people to buy health insurance whether they can afford it or not? Can the Federal Government then impose a criminal fine on them under the guise of calling it a tax if they fail to buy the insurance?

What happens if the citizen doesn't pay the fine? Do they go to jail without the benefit of trial by jury? Do they lose their right to confront witnesses and have a lawyer?

Congress forcing mandatory health insurance on Americans and then imposing criminal sanctions without due process is a violation of the Constitution. This action would shock the Framers of our Constitution.

These serious constitutional issues cannot be ignored and I strongly oppose H.R. 3962 and any other bill that violates our Constitution.

Mr. Speaker, I am strongly against H.R. 3962, and I will vote against it should it come to a vote on the House floor. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week's devastating news that unemployment has reached 10.2% it is critical that we preserve jobs in the United States. While the innovators, have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should occur in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. KIRK. Mr. Speaker, our goal in health care reform should be to lower the cost of health care, making it more affordable for Americans to purchase coverage. Many young adults from Illinois and elsewhere will be hit very hard under this legislation if they do not have coverage provided by their employers. We should not force young Americans to purchase coverage that costs them more because of reform. This is a new expensive tax targeted to young workers—and I oppose it.

According to the Department of Health and Human Services, 29 percent of individuals between the ages of 18 and 24 are uninsured and 27 percent of individuals between the ages of 25 and 34 are uninsured. Prices in the individual insurance market are already so high they do not think it is worth it. The misnamed ''Affordable Health Care Act'' that we are debating now will make this coverage even more expensive.

The reason is that this bill requires that insurers may not charge 64-year-olds more than twice what they charge healthy 19-year-olds. This mandate will raise premiums on young adults tremendously. Young, healthy people who lack coverage, mostly because they find it too expensive at a current cost of $1,700 to $2,000 for it, will be forced to buy policies that cost $3,000, even after federal subsidies. The House bill's ''age rating'' of 2 to 1 is far below the 5 to 1 ratio currently prevalent in the insurance market. Why does this ratio exist? Simply because the medical bills of healthy young people are a fraction of what older Americans spend. Comparisons of the House bill with an estimate of what is available on the individual market now using data provided by the Kaiser Family Foundation demonstrate that a 25-year-old single individual making $30,000 will pay a premium of $3,169 under the House bill after subsidies, while similar standards with a 4:1 age rating cost $2,258. It is almost a $1,000+ leap. This is a big deal for those earning only $30,000.

The Kaiser Family Foundation provides a way to estimate how insurance premiums will rise for young workers and their families:

	Salary	House bill	Current market	Higher premium
Single Policy:				
21	$30,000	$2,724	$2,258	$466
25	$35,000	$3,169	$2,258	$911
28	$40,000	$3,169	$2,435	$734
30	$42,000	$3,169	$2,676	$493
Family of Four:				
28	$75,000	$8,102	$7,402	$700
30	$90,000	$8,543	$7,862	$681

I proposed an amendment to this bill that would ensure that anyone purchasing insurance coverage after January 1, 2013 is exempt from the individual mandate if a less expensive insurance plan than those available under today's bill Act was available six months prior to its enactment. Unfortunately, this amendment was not made in order by the Rules Committee.

In health care reform, we should do no harm. We must enact reforms that will actually lower the costs of insurance premiums so Americans can afford to purchase coverage. Enacting a bill that makes it more expensive for young workers to buy insurance coverage and then forcing them to buy such coverage is wrong.

In closing, I want to commend Shauna McCarthy of my staff for the many months she has committed to health reform, contributing to this amendment as well as the Medical Rights and Reform Act, which seeks to prevent government intervention in the important relationship between patients and their doctors.

Mrs. MALONEY. Mr. Speaker, Sunday, 42,000 people gathered in my hometown of New York City to run the NYC marathon while 2 million more people watched, cheered, and marveled at those who accepted the challenge of running 26.2 miles. It is likely that each participant had a different reason for running, but the ultimate goal was the same: to finish, to

succeed, and to accomplish a goal. As Greek legend explains, the concept of the marathon comes from the long distance a messenger ran to deliver the important news that the battle had been won. Mr. Speaker, as we stand here today to debate a historical bill that will substantially improve the delivery of health care in America, we are the runners at mile 25. The cheers are the loudest, the anticipation is the greatest, and the end, while near, seems very far away. Despite all of the noise, the message is clear: now is the time for health care reform, now is the time to take care of all Americans, now is the time to make sure that families are not forced to see loved ones die because they did not get the care they need and deserve.

I'd like to thank and commend the leadership of Speaker PELOSI, Majority Leader HOYER, Chairmen WAXMAN, MILLER and RANGEL and of course, Chairman EMERITUS DINGELL who has been working on health care reform since he first came to Congress. H.R. 3962, the Affordable Health Care for America Act, is a significant and important step toward securing affordable, accessible, and quality health care for all Americans. Our current health care system is broken. Costs continue to increase at unsustainable rates and too many families and businesses are feeling the debilitating burdens brought on by these expenses. Too many Americans have inadequate coverage or lack coverage entirely and are suffering or dying as a result.

H.R. 3962 is critical to the health of our families, to the health of our economy and to the health of our nation;

H.R. 3962 lowers costs for every patient, reins in premiums, co-pays, and deductibles, limits out of pocket costs, and lifts the cap on the amount that insurance companies cover each year;

H.R. 3962 strengthens Medicare, securing the financial stability and solvency of Medicare for years to come, and provides seniors with better benefits and guaranteed access to their doctors;

H.R. 3962 reduces the deficit by over $100 billion in the first 10 years, and likely by even more in the following decade, according to the Congressional Budget Office;

H.R. 3962 provides affordable coverage to those who cannot get health insurance because of pre-existing conditions, including domestic violence and pregnancy, and protects consumers from higher rates due to gender or other factors;

And, very importantly, I am proud that H.R. 3962 includes a public health insurance option that will increase competition and reform our current system. I am grateful to Speaker PELOSI for her steadfast support of this important provision and am confident that it will expand access to care to the many people in need. When 14,000 Americans are losing their health care coverage each day, it is clear that a public option is needed. It will bring down costs, increase access, and improve care for all Americans. The richest country in the world should not have people who go without the basic necessity of health care. The public option will hold health insurance companies accountable for the practices that price people out of the health care they need and deserve.

Health care is the most important public policy issue of our generation that will affect generations to come. I am grateful for the opportunity to be a part of this momentous reform and would like to take the time to highlight some areas of the bill that specifically impact my Congressional district.

H.R. 3962 will improve employer-based coverage for 440,000 residents in my district and will provide credits to help pay for coverage for up to 120,000 households. It will also improve Medicare for 88,000 beneficiaries, including closing the prescription drug donut hole for 8,100 seniors. H.R. 3962 will allow 33,300 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 31,300 small businesses and will cover 26,000 uninsured residents. In short, H.R. 3962 will make health care affordable for the middle class, provide security for seniors, and will guarantee access to health insurance coverage for the uninsured while reducing the federal deficit over the next ten years and beyond.

In addition to representing the residents of the 14th Congressional District of New York, I am proud to represent 14 hospitals. Many of these are the jewels of American medicine, training our nations' doctors, and facilitating cutting edge research that identifies cures and gives hope to millions of Americans and their families. I am pleased that H.R. 3962 recognizes the importance of teaching hospitals and preserves Graduate Medical Education. New York's teaching hospitals, while training our future physicians, are treating the sickest of the sick and poorest of the poor. These payments, including Direct Medical Education and Indirect Medical Education are critical to the survival of these hospitals and to the greater good of medicine.

H.R. 3962 takes into account diverse patient populations, the cost of goods and services, and the higher costs incurred by teaching hospitals. Teaching hospitals tend to treat the most complex cases and are the first to adopt innovative technologies and techniques that advance patient outcomes, so their costs are often higher than average. A policy that reduces spending arbitrarily runs the risk of stifling innovation which is why I am pleased that the bill is sensible on how it addresses geographic variation. This bill recognizes the pitfalls of a blanket overhaul. It requires the Secretary of HHS to contract with the Institute of Medicine to conduct two studies. The first is a study of wage levels which will look at the hospital wage index and the physician geographic practice cost index and will recommend changes to the methodologies, if necessary. The second study looks at the geographic variation associated with volume and intensity of services in Medicare, Medicaid, and private sector spending per capita. The IOM is encouraged to understand and separate out higher-than-average spending due to unavoidable or desirable factors (e.g., patient demographic and clinical risk factors and wage levels) from higher-than average spending due to avoidable or undesirable factors (e.g., excessive medical errors, and practice patterns differing from best practices). The bill wisely includes specific prohibitions against recommendations to reduce graduate medical education, disproportionate share, and health information technology payments.

While I am pleased with the bulk of the bill, I am concerned that H.R. 3962 does not extend the 340B discounts to drugs purchased for inpatient use, a provision that was included in an earlier version of the bill. Currently, the 340B Drug Pricing Program requires pharmaceutical manufacturers that participate in Medicaid to sell outpatient drugs at discounted prices to disproportionate share hospitals (DSH) that serve a high threshold of low-income, uninsured and underinsured patients. Under current law, DSH hospitals participating in the 340B Drug Pricing Program pay approximately thirty percent more for their inpatient drugs than their outpatient drugs, although the drugs are frequently the same. The inpatient and outpatient settings serve the same low-income population that the 340B Drug Pricing Program was designed to assist. These discounts lower costs for patients and taxpayers. At a minimum, extending the 340B Drug Pricing Program to inpatient drugs would reduce inpatient drug costs by fifteen percent. These new resources could be better used to provide direct patient care. I am hopeful that during Conference, the House will cede to the Senate language and extend the 340B drug pricing to inpatient drugs. After all, now is not the time to deprive safety net hospitals from millions of dollars in savings needed to treat the most vulnerable in our communities.

Mr. Speaker, the task is huge and the rewards even bigger. Today we will vote to cover 96 percent of Americans without adding a dime to the deficit. We will be doing what's right for our families, what's right for our economy, and what's right for our future. I urge my colleagues to look at the larger picture and remember that today we will make a lasting difference in people's lives.

Mr. TERRY. Mr. Speaker, I rise today to make the House aware of a seemingly silent crisis facing millions of Americans and to offer a potential solution. I am talking about the problem of personal medical debt, and the critical need for medical debt counseling. As a result, thousands of Americans in my state of Nebraska and throughout our nation are facing extremely difficult choices that severely impact their quality of life, and sometimes life itself.

Mr. Speaker, I am sure my colleagues are aware that medical debt is the number one cause of personal bankruptcy in this country. Let me say that again: 60 percent of all personal bankruptcies are the result of crushing medical debt. I know that my colleagues would agree that this is an astonishing, and indeed, an embarrassing statistic for our country.

In most cases, those who suffer from serious medical debt are people with chronic diseases who have just enough insurance to be considered insured. While they may technically be insured, the fact of the matter is that in reality they are severely underinsured. Simply put, they are faced with some extremely difficult choices between whether to pay their medical bills or pay for their basic needs. For example, someone with a chronic disease who is saddled with extremely high medical debt may have to choose between paying their mortgage or putting food on the table and paying the bill for life-saving treatments for their disease.

It is not hard to understand that when faced with these kinds of options more than half the time people chose to declare bankruptcy. That means that hospitals take a loss, individuals who have declared bankruptcy ruin their credit, and the American people in the end typically pay for it all.

Mr. Speaker and my colleagues, we can help fix this crisis with medical debt counseling.

The idea behind medical debt counseling is simple: Create a network of non-profit organizations that provide counseling services specifically for medical debt. The nonprofit counselors will provide the participants with a number of options long before the idea of bankruptcy is even considered. This is a win-win for everyone. A person can avoid bankruptcy, and a health care provider such as a hospital or doctor, can receive payment for their services.

Nonprofit organizations with expertise in helping under-insured people with chronic diseases manage their burden, such as the Chronic Disease Fund which assists people in my state, should be put on the front lines of providing effective medical debt counseling. They are the experts which are best equipped to provide effective counseling so that individuals will not be forced into declaring bankruptcy because of their medical debt.

To my knowledge, there is nothing in the pending health care reform legislation that would help encourage medical debt counseling. This brings me to an important point. Because we have moved so fast on health care reform legislation, good ideas like medical debt counseling are not part of this bill. We need options like this for health care reform because it will work to save the American taxpayer money. Medical debt 2 counseling will reduce the cost burden on the health care system, not increase it. And medical debt counseling is innovative. It is innovation like this that made America's health care the best in the world.

Mr. Speaker, my constituents, like yours, provide for their families but they live on a tight budget. When faced with the reality of making a huge medical bill payment or putting food on the table, what do you think they are going to do? We can help them avoid this terrible scenario. Again, 60 percent of bankruptcies in this country are because of crushing medical debt. We can help lower the number of personal bankruptcies across this great nation, but to do so we need to encourage a system of medical debt counseling.

Ms. KILPATRICK of Michigan. Mr. Speaker, I rise today in support of H.R. 3962, Affordable Health Care for America Act, offered by Rep. JOHN DINGELL of Michigan and ask all of my colleagues to support this historic bill before us that will expand coverage to 36 million uninsured Americans, ensure that patients and physicians make their own health care choices, reduces administrative costs, invests in wellness and prevention, reforms the insurance industry by ending discriminatory practices, especially pre-existing conditions and health disparities, and allows young adults to remain on their parents' insurance policy until the age of 27.

I have held numerous town hall meetings in my district to listen to the views of my constituents. My office has received numerous calls, emails, and letters on this subject, with an overwhelming majority asking me to vote YES on the bill because America cannot wait any longer for health care insurance reform. More than 300 groups, representing millions of Americans, have expressed their support for the bill, including the American Association of Retired Persons, the American Cancer Society, the United Auto Workers, the AFL-CIO, the SEIU, Families USA and the National Committee to Preserve Social Security and Medicare. The groups expressing their support include a broad range, including groups representing doctors, seniors, small business, youth, women, persons with disabilities, consumers and patients.

Health care insurance reform is not a Republican or Democratic issue, it is an American issue. Under a Democratic President, we witnessed the beginnings of health care reform with Medicaid and Medicare in the 1960s. Under another Democratic President, we will witness the second coming of true health care reform.

Today's vote will mark a change in our country where every American will know that health care is a top priority for this country. When I was a newly elected Member to the U.S. House of Representatives, Congress was in the throes of reforming health maintenance organizations or HMOs. While this was well intended, at the time, I asked, ''what about those millions of people who go to work each and every day, who care for our senior citizens in nursing homes, who clean our bathrooms, cook our food, clean our streets, and send their children to college, but whose employers do not provide health care?'' What happened is that those individuals did not have health care coverage, period. Now is the time to help those janitors, street sweepers, short-order cooks, child care workers, home health care providers, and small businesses so that those workers, too, will be able to have health care.

The 111th Congress has taken bold steps to provide more access to health care for Americans. While we have expanded health coverage to more than five million uninsured children through the passage of the State Comprehensive Health Improvement Plan or SCHIP, we must complete what we started. Access to health care is vital to the health of not only individual Americans but to the American economy.

Even before our recent economic crisis, health care was getting more expensive, what few benefits were offered were eroding, and even more people were losing coverage. In 2007, according to various sources, 45 million Americans were uninsured; this number is an increase over 2000's 38.7 uninsured Americans. And this is the uninsured; we are not even discussing the millions more senior citizens, working poor and families who are underinsured. I am talking about seniors who have to choose between eating or their prescriptions. I am talking about those families who have to choose between taking their child to the doctor or food for the week. The economic crisis has only made this situation worse.

The bankruptcy of the automobile industry, the closing of auto dealerships, and the crisis faced by automobile suppliers have caused thousands more in our Nation and in particular the state of Michigan to lose their employee health benefits.

Our version of health care reform, the Affordable Healthcare for All Americans Act, has four key highlights for Americans and American businesses: lower costs; greater choice; higher quality and peace of mind. As Health and Human Services Secretary Sebelius said earlier, if we do nothing to reform health care, we will continue to live sicker, die faster and pay twice as much.

Health care reform legislation should require coverage of the full range of women's reproductive health services. H.R. 3962 protects these rights and ensures that all women have access to a health care plan that meets their needs while respecting current law. The Stupak amendment would limit access to reproductive care in the private and public options, and does not allow citizens to pay for the procedure out of their own pockets. I voted against the Stupak amendment.

HEALTH CARE REFORM WILL PROVIDE LOWER HEALTH CARE COSTS

Under the America's Affordable Health Care Act, there will be no more co-pays or deductibles for preventive care. No more rate increases or exclusions for pre-existing conditions, gender or occupation. There will be an annual cap on the out of pocket expenses for individuals and businesses. Finally, for the first time, there will be guaranteed and affordable oral, hearing, and vision care for children.

By having a public health care plan, the bill will ensure competition for Americans to have the best health care at the most affordable cost. Also, since everyone will have health care, no one industry or business will be at an advantage over another one.

HEALTH CARE REFORM WILL PROVIDE GREATER CHOICE FOR ALL AMERICANS

Americans will be able to keep their doctor, and their current plan, if you like what you have. With a high quality public health insurance option competing with private insurers, there will be more choice of providers and more benefits. The important aspect is this—every American will have a choice of providers, versus today's choice, for the uninsured, of the emergency room or no care at all. No one will be forced into a public option. This will just be one of many choices.

HEALTH CARE REFORM WILL PROVIDE HIGHER QUALITY HEALTH CARE FOR ALL AMERICANS AND BUSINESSES

You and your doctor—not insurance companies—will make health care decisions. As more primary care, family doctors, and nurses enter the workforce, even more access is guaranteed for all Americans. Also, the bill mandates coverage for mental health care, a key issue that will affect, in particular, the families of our service members who are returning from the wars in Iraq and Afghanistan.

HEALTH CARE REFORM WILL PROVIDE PEACE OF MIND

The bill provides a cap on catastrophic coverage—coverage for traumatic injuries such as spinal cord injuries and long-term health care. There will be no more denial of coverage for preexisting conditions, and no reason to make a life or job decision based on whether or not you or your family will have health care coverage.

We need health insurance reform now. Access to quality, affordable health care is critical to the well-being of all Michiganders and all Americans, today and tomorrow. Central to all of this is addressing the needs of uninsured Americans, strengthening our Medicare system, providing health insurance to low-income children and families, funding research into diseases like diabetes and cancer, and giving patients the ability to make decisions with their doctors, not health insurance companies. An estimated 1,400 families lose health insurance every day that we do not pass health insurance reform.

One aspect of this legislation of which I am most proud is its fiscal responsibility. According to a letter dated November 5, 2009 from the non-partisan, objective Congressional Budget Office, this bill adds not one dime to

the deficit. Furthermore, this bill reduces the deficit by an estimated $109 billion. This is not only fiscally responsible, it allows us to provide health care to the least of our sisters and brothers.

When this bill is signed into law, ten provisions of the bill will take effect immediately:

It will begin to close the Medicare Part D ''Donut'' Hole. The bill reduces the donut hole by $500 per Medicare recipient and also institutes a 50-percent discount on brand-name drugs.

It gets health insurance to the uninsured. By creating a temporary insurance program, health care will be available for people who have been denied a policy due to preexisting conditions or who have not had health care for several months.

It bans lifetime limits on health care coverage. The bill prohibits health insurance companies from placing lifetime caps on coverage—traditional coverage or catastrophic care coverage.

It provides health insurance for young people. It requires health insurance plans to allow young people through age 26 to remain on their parents' insurance policy at their parent's choice.

It eliminates cost-sharing for preventive services in Medicare. It eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program.

It ends health care rescissions. It prohibits insurers from nullifying or ''rescinding'' a patient's policy when they file a claim for benefits, except in cases of fraud.

It bans copayments and deductibles. It eliminates copayments for preventive services and also exempts preventive services from deductibles under the Medicare program.

It increases funding for community health centers. It increases funding for Community Health Centers to allow twice the number of patients seen by Community Health Centers for the next 5 years.

It increases the number of primary care doctors. It increases the investment by the Federal Government in training programs to increase the number of primary care doctors, nurses, and public health professionals.

Creates long-term health care for disabled adults. The bill creates a longterm care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become functionally disabled.

As with Medicare and Medicaid, the Federal Government has the Constitutional power to reform our health care system. The 10th amendment to the U.S. Constitution states that the powers not delegated to the federal government by the Constitution, nor prohibited by it to the states, are reserved to the states . . . or to the people. Article One, Section Three, also known as the Commerce Clause, says the same thing. The Constitution gives Congress broad power to regulate activities that have an effect on interstate commerce. Congress has used this authority to regulate many aspects, from labor relations to education to health care to agricultural production. Since virtually every aspect of the heath care system has an effect on interstate commerce, the power of Congress to regulate health care is essentially unlimited.

The Affordable Health Care for America Act is good for small businesses. Under this legislation, many small businesses will be eligible for a new tax credit to help them provide coverage for their workers and their families—and they or their workers will get access to a new comparison shopping marketplace with low rates and good benefits like large groups get. Without health insurance reform, small businesses would pay nearly $2.4 trillion over the next 10 years in health care costs for their workers. According to the nonpartisan Joint Committee on Taxation—only 1.2 percent of the wealthiest Americans will be subject to the surcharge and it would only apply to dollars earned over $1 million for a couple and $500,000 for an individual. Furthermore, 86 percent of all businesses are exempt from the requirement to provide health insurance coverage to their workers.

Nothing in the House bill will cut basic Medicare benefits. The Affordable Health Care for America Act strengthens and improves Medicare benefits for older Americans and helps eliminate waste, fraud and inefficiency from Medicare—including gross overpayments to insurance companies providing Medicare Advantage plans which do nothing to improve care for Medicare Advantage beneficiaries.

The Affordable Health Care for America Act is comprehensive health insurance reform that covers 96 percent of Americans, ensures affordability for the middle class, provides security for our seniors, ends discrimination by insurance companies against the sick, caps what Americans pay out-of-pocket and protects our children's future by not adding to our deficit.

Finally, health care reform will allow the United States to catch up to the rest of the industrialized world. We are the only nation that does not provide universal health care coverage to its citizens. This puts the health of not only individual Americans at jeopardy, it puts the health of our economy in jeopardy. Businesses that have to compete with China, India, Europe and other countries are doing so on an uneven, unfair playing field, because while China, India and European businesses do not have to pay for health care, American businesses do. Health care reform will allow these businesses to truly compete on a global plane.

I applaud my colleagues in the House of Representatives for supporting this legislation in ensuring that health care reform is accessible, available, and affordable for all Americans and American businesses. Two generations is long enough for the American people to wait for comprehensive health care reform. Health care is the key moral and economic imperative for our Nation and this Congress. We must reform health care now.

Ms. CLARKE. Mr. Speaker, today, I rise in support of H.R. 3962, Affordable Healthcare for America Act. In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance, 13.5 percent of which are New Yorkers. Last year alone, New York City's hospitals spent 1.2 billion dollars in charity costs. Tragically, people who are either uninsured or underinsured often have to go without vital healthcare simply because they cannot afford it.

Every American has a human right to adequate physical and mental healthcare, and I believe that government has a responsibility to assist its citizens in securing quality healthcare. Unfortunately, my Republican colleagues don't seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare.

It is unfortunate that there are those who just don't care. Those who are satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of preexisting conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured. Instead of working to fix the problem, they capitalize on people's fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens. Today we will not allow the voices of fear to dominate the health care reform debate. This bill provides healthcare coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Health Care for America Act.

In my district, the 11th Congressional District of Brooklyn, the Affordable Health Care for America Act will:

First, improve employer-based coverage for 367,000 residents. As a result of the insurance reforms in the bill, there will be no co-pays or deductibles for preventive care; no more rate increases or coverage denials for pre-existing conditions, gender, or occupation; and guaranteed oral, vision, and hearing benefits for children.

Second, it will provide credits to help pay for coverage for up to 160,000 households, if they need to purchase their own coverage.

Third, under the bill's insurance reforms, 11,900 individuals in the district who have preexisting medical conditions will now be able to purchase affordable coverage.

Finally, this bill will allow 11,300 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 11,400 small businesses.

Healthcare is a fundamental human right, rather than a commodity. A year ago, Americans cast a historic vote to change the course of this Nation. Today, we cast this historic vote, to finally manifest the change they demanded. Access to Affordable Healthcare. I am proud to cast my vote in favor of this bill.

Mr. Speaker, I believe that H.R. 3962, the Affordable Health Care for America Act, will improve health care for all of our constituents. Another significant benefit of this legislation, which has not received as much attention, will be the creation of new high paying jobs, high quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring that the millions of Americans, who currently have no insurance, will have access to primary care providers so that they can receive the preventive care they have been denied for too long. This influx of new patients will create a need for doctors, nurses and technicians, while reducing overall healthcare costs because of the new focus on preventative medicine. I support channeling resources, that for too long have been used to treat people once they become sick, into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better

manage both the quality of care and the cost of it. New health care exchanges and new demands on the health system to provide high quality and cost-effective health care will create new opportunities and markets for our brightest technological minds. They will be incentivized to develop high quality healthcare products at an affordable price.

Third, this bill will create new research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures, thereby allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing. This research will create high quality, high paying jobs. It is imperative that we keep this research, and these jobs in this country. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

I do not look at this bill as a drain on our economy, like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country, while at the same time improving the lives of all Americans. This bill will improve health care, create jobs and grow our economy.

Mr. FATTAH. Mr. Speaker, in my fourteen years representing the people of Philadelphia and Montgomery County, Pennsylvania, I have had few opportunities as significant as this one to stand up for my constituents, their families, the future of our city and the destiny of our nation. This healthcare bill is the result of months of legislative negotiation and collaboration and answers the calls made for decades by mothers who could not alleviate the suffering of their children, conscience-minded small business owners who could not provide the healthcare coverage they knew their employees deserved and doctors and nurses who fought creatively to provide treatments they knew their patients needed and could never afford. I am proud that today we will take the most significant step in a century towards joining the rest of the industrialized world in assuring every American has access to the healthcare they need.

It is the nature of democracy that this bill contains some provisions which I do not support. I believe women deserve access to the full range of legally assured health services on equal footing with men. I believe it is our responsibility to vigorously address the pernicious health disparities which disadvantage Americans of color and linguistic minorities. I believe overzealous efforts to deny some people healthcare on the basis of their immigration status will inadvertently limit care for native-born and legal residents as well. I believe a stow public option is the only way to ensure competition, choice and affordability in the American private insurance market. At the end of the day, we, as the Representatives of the people are called to speak for them. Rarely do we have the opportunity to so directly improve their standard of living. It is with the people of the Second District in mind, and the generations to come, that I enthusiastically vote yes for the Affordable Health Care for America Act.

Ms. WOOLSEY. Mr. Speaker, at least 46 million Americans are uninsured right now. More than 85% of the uninsured are in working families. Even if you have health insurance now, without reform, the cost of health care for the average family of four is projected to increase by almost $2,000 a year. The need for health reform is urgent and that's why I rise in strong support of this historic bill.

Many Members of Congress, myself included, continue to believe that the best way to provide high quality, affordable healthcare to everyone is to create a single payer health insurance system. However, while we would prefer single payer, we united behind a health reform bill with a robust public option.

We believed, and still believe, that the robust public option, a public option based on medicare plus 5% rates is the best way to increase competition, bring down the costs of premiums, and provide everyone with a real choice between a private and public health insurance plan.

In August, many thought the public option was dead. But the Progressive Caucus, Tri Caucus, and many in our leadership, made sure that the robust public option was very much a part of the debate in September and October.

Because of the work of so many Members, we have a public option in the bill we are considering today. While it's not the plan I would have preferred, this public option will increase competition with private plans and provide a real choice in health insurance plans.

In addition, there is language in the manager's amendment that will ensure that any increase in health insurance premiums must be justified, which will help make premiums more affordable for our Nation's working families.

As we move into conference with the Senate, I look forward to continuing to work with my colleagues to ensure that we have the best possible bill. Therefore, Mr. Speaker, to increase competition and provide choice, any bill reported out of conference must retain a strong national public option that goes into effect when the health exchange begins, and, is not based on any triggers. I urge my colleagues to support this bill.

Mr. HARE. Mr. Speaker, I wish to strongly voice my support for the Affordable Health Care for America Act on behalf of all hard working men and women across this great country and certainly in the State of Illinois.

For decades, our government has debated the issue of extending healthcare to all, yet too many Americans still lack it and the security and peace of mind that comes with it. For those fortunate enough to be insured, rising costs are making it harder and harder to stay afloat. We, as members of this body, have the opportunity today to take a historic step toward passing the Affordable Health Care for America Act, so that quality health care can be more affordable and accessible to all Americans and their families. This bill will drastically reduce the number of uninsured, increase competition and lower costs through a public option, reform the insurance industry so Americans don't see their coverage unfairly denied or dropped, and put more money in our seniors' pockets by closing the Medicare Part D doughnut hole, all while reducing the deficit by $104 billion over 10 years.

With unemployment at its highest level since 1983, another significant benefit of this legislation that should be highlighted is the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in the United States. This bill creates a framework for allowing biosimilar competition in this country, which has the potential to lead to a new class of generic biologic medicines that will help lower costs and bring competition to one of the areas that will be key to the future of our healthcare system. The development of generic biologics or biosimiliars has the potential to create much needed jobs here at home in clinical research and testing. I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that this new work is conducted here at home, in places like my home state of Illinois.

This bill will additionally create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of Americans in this country who currently have no coverage will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and technicians for their care, while reducing overall healthcare costs because they will receive care based around prevention as opposed to hospitalization. I support channeling resources, that for too long have been used to treat people once they become sick, into jobs and services that will prevent people from getting sick in the first place.

The Affordable Health Care for America Act will continue the efforts this Congress first undertook in the Recovery Act that deployed new health information technologies throughout our healthcare system. These technologies help to better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our economy. Workers and industry together will be incentivized to create and develop products that will be a win/win for Americans: high quality health care at an affordable price.

I was proud to work with my colleagues on the Education and Labor Committee to help shape this bill. I was pleased to have had the opportunity to add two critical pieces to this bill that are of great importance to my constituents: allowing for Small Employer Benefit Arrangements (SEBA), which facilitate the participation of small businesses and the self-employed in the Health Insurance Exchange; and protecting the ability of our nation's veterans to be able to enter into the Health Insurance Exchange to attain additional insurance for their dependents while retaining their VA health coverage. These provisions were common-sense improvements that make this great bill even better.

I have cited many, but not all, of the reasons why I think this historic bill is worthy of my vote. I now ask that my colleagues join me in protecting American families from coast to coast in supporting this historic legislation. Mr. Speaker, thank you for your strong leadership on this issue and I look forward to proudly voting in favor of this bill in honor of the 39,000 uninsured residents of my District who would

finally have the ability to receive the quality health care they deserve.

Mr. PASCRELL. Mr. Speaker, I and others have spoken at length on the ways that the Affordable Health Care for America Act will improve health care for all of our constituents. Another significant benefit of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle: this bill will create high-paying, high-quality jobs in health care delivery, technology, and research in the United States.

First, H.R. 3962 will create enormous demand for health care workers, especially in the area of primary care. Expanding meaningful health insurance coverage to the millions of Americans in this country who are currently uninsured or underinsured will allow them to see the primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need the doctors, nurses, and technicians necessary to deliver the care they need—while reducing overall health care costs as we prevent more expensive emergency care and hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, the Affordable Health Care for America Act will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective care will create new opportunities and markets for our brightest minds in technology. They will be incentivized to create and develop products that will be a win-win for Americans—high quality health care at an affordable price.

Third, H.R. 3962 will create high quality research opportunities for America. The legislation under consideration establishes a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to an area that is a key to the future of our health care system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures and allow our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of new biosimilars' interchangeability with innovator products. This research will create high quality and high paying jobs, and it is imperative that we keep this research and these jobs in this country. The Inspector General of Health and Humans Services is currently investigating the amount of data received from overseas clinical trials. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that the clinical studies to support the safety and interchangeability for this new class of follow-on biologics is conducted in the United States.

Mr. Speaker, I do not view this legislation as a cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. Instead, the Affordable Health Care for America Act is an exciting opportunity to create the kinds of jobs we so desperately need in this country while improving the lives of ALL Americans. H.R. 3962 will improve health care, create jobs, and grow our economy.

Mr. PASCRELL. Mr. Speaker, I am pleased to support the Affordable Health Care for America Act. I could not be prouder that H.R 3962 expands coverage to 96 percent of Americans in a fiscally responsible manner. I strongly believe that all interested parties should indeed have a stake in this necessary effort, but I would like to recognize the contribution asked of the biopharmaceutical industry.

New Jersey has often been called the Medicine Chest for the World and for good reason. Last year, the biopharmaceutical and medical technology industries employed nearly 60,000 individuals in the state of New Jersey—with another 88,000 ''spin-off' jobs through the purchase of goods and services, capital construction projects, and other industry activity.

H.R. 3962 extends Medicaid rebates to Medicare dual-eligible and low-income subsidy beneficiaries while instituting a new 50 percent discount for Part D beneficiaries who find themselves in the prescription drug benefit coverage gap—the so-called ''donut hole.'' Pharmaceutical sales represent about 10 percent of national medical expenditures, but the savings generated from these provisions represent a disproportionately larger share of the legislation's savings and revenues.

There is little doubt that these industries are sure to see increased sales both as millions of previously uninsured Americans and millions more who were underinsured are given access to meaningful health insurance that covers prescription medications and as seniors with expanded Part D coverage better adhere to the prescription regimens prescribed by their doctors. However, I have lingering concerns that a single industry may be paying more than their fair share and that this may have unfortunate consequences in New Jersey. The biopharmaceutical manufacturers in my state have estimated that as many as 12,300 jobs could be lost in New Jersey.

I believe that H.R. 3962 is an effort that will indeed create new jobs in the health care sector both as the demand for health care providers increases and as the result of a new pathway for the development of follow-on biologics, and I applaud the legislation for taking steps to close the Medicare Part D donut hole. However, we must recognize there will be consequences for New Jersey's biopharmaceutical industry, and I express my hope that these consequences will be minimized as the House and Senate come together to formulate a compromise health reform package.

Mr. PASCRELL. Mr. Speaker, in my capacity as co-chair of the Congressional Brain Injury Task Force, I would like to share my understanding of the intent of the provisions of H.R. 3962—the Affordable Health Care for America Act—regarding the coverage of the treatment continuum for persons with brain injury.

News reports of returning veterans and recent high profile brain injury stories indicate what researchers have been reporting for years: brain injury is a leading public health problem in U.S. military and civilian populations. I believe that any health care reform initiative must recognize that brain injury is not an event or an outcome but is the beginning of a lifelong disease process that impacts brain and body functions. These impacts of brain injury can result in difficulties in physical, communication, cognitive, emotional, and psychological performance, undermining health, function, community integration, and productive living. Brain injury is also disease causative and disease accelerative because it predisposes individuals to re-injury and the onset of other conditions.

The Brain Injury Association of America (BIAA) has developed a series of guiding principles for assessing any health care reform bill from a brain injury perspective. I believe, consistent with policy statements by the BIAA, that health care reform must address the unique health care needs of individuals with brain injury by recognizing that brain injury is the start of a lifelong disease process. As such, individuals with brain injury require access to a full continuum of medically necessary treatment—including rehabilitation furnished by accredited programs in the most appropriate treatment setting as determined in accordance with the choices and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to conclude that the Affordable Health Care for America Act reflects and is consistent with these principles.

Principle 1: An individual with a brain injury should have an individualized medical treatment plan that documents specific diagnosis-related goals for individuals with a reasonable expectation of achieving measurable functional improvements through the provision of sufficient treatment.

Under the bill, payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical and other appropriate clinical or professional practice. In addition under the bill, a qualified health benefits plan may not impose any restriction (other than cost-sharing) unrelated to clinical appropriateness on the coverage of the health items and services included in the essential benefits package. Consistent with medical, clinical, and professional practice, appropriateness should be determined based on the unique needs of the individual with brain injury and treatment should be of sufficient scope, duration, and intensity.

Principle 2: An individual with brain injury should have access to the full treatment continuum to manage the disease. This continuum includes (1) early, acute treatment to stabilize the condition and (2) acute and specialized post-acute brain injury treatment and rehabilitation to minimize and/or prevent medical complication, recover function and cope with remaining physical or mental disabilities, and achieve long-term outcomes that maintain an optimal level of health, function, and independence following brain injury. These post-acute services include inpatient, outpatient, day treatment, and home health programs. I believe that for individuals with disabilities such as brain injury, rehabilitation and habilitation is equivalent to the provision of antibiotics to a person with an infection—both are essential medical interventions.

I am pleased to report that under the bill, the essential benefit package includes, among other things, hospitalization, outpatient hospital

and outpatient clinic services, professional services of physicians and other health professionals, prescription drugs, mental health and substance use disorder services (including behavioral health treatments), rehabilitative and habilitative services, and durable medical equipment, prosthetics, orthotics, and relates supplies. The term ''rehabilitative and habilitative services'' includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, disorder, or other health condition. Such services also include training of individuals with mental and physical disabilities to enhance functional development.

Principle 3: Individuals with brain injury should receive treatment in the most appropriate treatment setting by accredited programs—including acute care hospitals, inpatient rehabilitation facilities, residential rehabilitation facilities, day treatment programs, outpatient clinics and home health agencies. The treatment and treatment setting should be determined in accordance with the choice and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to report that under the bill payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical or other appropriate clinical or professional practice. The bill also requires adequacy of provider networks in order to ensure enrollee access to covered benefits, treatments, and services under a qualified health benefits plan. Rehabilitative and habilitative services should be available from a full continuum of accredited programs and treatment settings at a level of intensity that is consistent with the needs of the patient.

Principle 4: The bill should prevent private insurance systems from delaying or denying treatment as a means of transferring the burden of brain injury care to taxpayers at federal, state and local levels; ensure that both public and private health insurance systems meet the health care needs of people with brain injury; and avoid using Medicaid and Medicare as the first option for the coverage of people with brain injury.

I am pleased to report that the bill includes numerous requirements reforming the health insurance marketplace that should prevent private insurance systems from delaying or denying treatment for individuals with brain injury. These reforms include (1) prohibiting pre-existing condition exclusions, (2) requiring guaranteed issue and renewal, (3) requiring nondiscrimination in health benefits or benefit structure, (4) requiring adequacy of provider networks, (5) limiting cost-sharing, and (6) prohibiting the imposition of annual or lifetime limits on coverage. I believe that these provisions will help prevent private insurance from delaying or denying treatment to persons with brain injury.

Finally, the bill includes provisions regarding modernized payment initiatives and delivery system reform under which the Secretary may use innovative payment mechanisms and policies to determine payment for items and services under the public health insurance option, including bundling of services. Separate provisions are included in the bill regarding post-acute care bundling under Medicare. BIAA, in a recent submission to the chairs of the Education & Labor, Ways & Means, and Energy & Commerce Committees, commented that post-acute payment systems must facilitate, not impede, improvements in functional status of individuals with brain injury and their ability to return to their homes and communities. BIAA supports a deliberative planning process and rigorous pilot testing. According to BIAA's comments, the deliberative process should determine whether post-acute care bundling should exempt diagnoses such as brain injury, that are of low predictability and highly complicated; establish certain minimum requirements for any bundling proposal such as ''any willing provider'' in the bundled payment system; and test innovative payment methods that make payments directly to non-hospital-based treatment centers, including residential rehabilitation facilities specializing in the treatment of brain injury.

I believe that the deliberative process should address each of these issues. I also believe that the adoption of alternative innovative payment mechanisms and policies must be guided by the goals included in the bill—improving health outcomes, reducing health disparities, providing efficient and affordable care, addressing geographic variation in the provision of health services, preventing or managing chronic illness, and promoting care that is integrated, patient-centered, quality, and efficient.

I remain wary of mechanisms that bundle post-acute care to acute care hospitals for patients with complex and highly unpredictable diagnosis and health outcomes, like brain injury and other catastrophic conditions. Such payment systems should not impede, rather than facilitate, improvements in functional status and should not result in premature return to homes and undue levels of preventable disability without adequate facilitation of progression through necessary step down levels of treatment.

Mr. LUETKEMEYER. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so.

However, one bi-partisan area that strikes the appropriate balance in providing lower-cost options to consumers without destroying a healthy and functioning industry in this country that is included in both the underlying bill, which I strongly oppose, and the Republican substitute, which I intend to support, are the sections relating to the creation of a market for biosimilar products. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time, providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week's devastating news that unemployment has reached 10.2%, it is critical that we preserve jobs in the United States. While the innovators have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should be occurring in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. EDWARDS of Texas. Mr. Speaker, after listening to thousands of my constituents and carefully reviewing the legislation, I have made a decision to vote ''no'' on the House health care reform bill.

Given the huge federal deficits facing our nation, I believe there is too much new spending in this bill.

I am especially disappointed that the bill does not have a fiscal trigger in it to cut spending if actual costs of new programs turn out to be higher than projected.

While the Congressional Budget Office predicts this bill is paid for over 10 years, there is no mechanism in the bill to force spending cuts if those complicated projections turn out to be wrong.

I also have concerns about a government-run ''public option'' insurance company and question whether this bill goes far enough in actually reducing health care costs for working families and businesses.

Throughout this debate I have heard two extremes. Some on the far left would like to see the federal government run a socialized health care system. Some on the far right would get the government completely out of health care, which would mean the elimination of Medicare and Medicaid. I think both extremes are wrong.

I believe most people in our district recognize that health care reform is needed to hold down costs and to make health care more affordable and dependable, but they want any reform bill to be fiscally responsible. I agree.

Mr. SHUSTER. Mr. Speaker, after weeks of closed-door meetings, Speaker NANCY PELOSI has brought her healthcare reform to the floor for a vote today on Saturday while the attention of the majority of Americans is diverted. The Pelosi plan clocks in at over 1,900 pages, which is 648 pages longer than Hillary-care and it costs over a trillion dollars, or about $2 million per word.

The sheer size and scope of the Pelosi plan is enormous. As we enter a time of 10.2 percent unemployment, the American people will

not accept a government takeover of healthcare that will kill even more jobs, hurt small businesses, increase the deficit now and drown future generations in stifling debt.

While the sheer size and scope of the Democrats' takeover of healthcare prevents me from pointing out every egregious part of the proposal, I would like to point out four areas that should give all Americans pause.

Taxes: The Pelosi plan would impose $730 billion in new taxes on businesses that can't afford to pay for their employees' health coverage. According to President Obama's own economic advisor, Christina Romer, these new taxes would put 5.5 million workers at serious risk of losing their jobs. Close to 32,500 small businesses in Pennsylvania would be at risk from this new healthcare surcharge.

Deficit Spending: The Pelosi plan contains $1.055 trillion in new federal spending over the next ten years. All of this spending will be used to take healthcare decisions out of the doctor's office and centralize them in Washington, DC, requiring the creation of over 100 new federal panels, commissions and unelected civil servants who will be charged with making decisions on your care.

Senior's Coverage: Earlier this year, President Obama pledged that ''the government is not going to make you change plans under health reform.'' Today, he and NANCY PELOSI are proposing $170 billion in cuts to Medicare Advantage. These cuts would force close to 38,000 enrollees in the 9th district out of Medicare Advantage and into regular Medicare.

Personal Freedom: The Pelosi plan will bring the nationalization of one-sixth of our economy and the elimination of choice for a majority of Americans to extend coverage to a few.

Republicans have an alternative focused on simple principles that will lower the cost of quality healthcare for all Americans. Our plan would let families and businesses buy health insurance across state lines and pool together and buy health insurance at lower prices. We would give states the tools to create their own innovative reforms that lower health care costs. Finally our plan would end excessive and unnecessary tests doctors perform that contribute to higher health care costs to protect against junk lawsuits.

Real health care reform should foster a system where competition and patient choice drive quality care and success. I believe we can accomplish this and fix what is broken in our health care system without forcing another trillion-dollar government takeover on taxpayers. I urge all of the members of this House to vote no on this reckless reform package. Vote no on a government takeover of healthcare.

Mr. PUTNAM. Mr. Speaker, America is at a crossroads and we, as Members of Congress have the duty and responsibility to ensure our great country remains vibrant and competitive in the 21st Century. For that reason, I cannot figure out why the Democratic leadership and the administration want to rush to pass this monstrosity of a bill, with its $1 trillion price tag and $730 billion in taxes. I can confidently say that passing this health care reform bill will unwind private health care in America and at the same time do very little to bring down its cost.

I rise today to speak in strong opposition to the legislation before us, H.R. 3962. This measure is indeed historic—an historic expansion of the role of government in the lives of every American. Your choice of physician . . . your choice of medical facility . . . your choice of the kind of care and treatment you receive . . . these are some of the most personal decisions you can ever make. The prospect of placing those decisions into the hands of a new federal bureaucracy that would combine the efficiencies of FEMA with the compassion of the Department of Motor Vehicles ought to alarm every American.

So we are gathered here, to vote on legislation that is nearly twice the length of the original bill, H.R. 3200, that was introduced this summer. Mr. Speaker, I doubt that there are many people in this great hall who can honestly tell you they are fully conversant with every provision in this bill. But after doing our best to read, study and understand the nearly two-thousand pages of H.R. 3962 we know certain things this bill will do. For example, we know it will cost taxpayers more than a trillion dollars. We know it will impose $730 billion in new taxes on small businesses and individuals. We know it will cost five-and-a-half million Americans their jobs. We know it will create over 100 new bureaus, commissions, and programs. And we know it will burden our states with tens of billions of dollars in new unfunded federal mandates. In Florida alone, the additional costs associated with the Medicaid mandates will be in the billions of dollars.

Mr. Speaker, we are told by the President and by the majority party in Congress that we need all this in order to make health care more affordable for the American people. How are we making health care more affordable if we are driving the American people into bankruptcy by taking historic steps toward a federal takeover of the entire health care system?

The Democrat Majority seeks to pay for their health care reform bill in part through 8 percent payroll penalty taxes on employers who cannot afford to provide insurance coverage, and through a 5.4 percent surtax on individuals making $500,000 a year or more. These provisions are estimated to bring in more than $595 billion.

You don't have to be an economist to know that these new taxes will have a direct and adverse affect on small businesses across America. An overwhelming majority of small businesses—approximately 75 percent of them—pay their business taxes through the owner at the individual level. Essentially, one in every three small businesses would be subject to the new surtax and just in the State of Florida as many as 57,000 small businesses would be affected. These provisions are effectively a tax on jobs that will stifle job creation and depress wages. In light of the latest unemployment numbers of 10.2 percent for the U.S. and 11 percent for Florida, this is hardly the time to raise costs on small businesses and employers.

If the taxes on America's small businesses were not enough, this bill also imposes a 2.5 percent tax on medical devices. At a time when our country spends about 17 percent of its GDP on health care, and we are tasked with developing policies to bring down the overall cost of care, it is irrational that we should tax an industry that is such an integral part of health care. This tax, on everything from syringes to artificial hips, will undoubtedly be passed along to the consumer.

Mr. Speaker, America has the best health care system in the world. Why should we destroy the economic backbone of America to create a government-run health care plan that the majority of Americans oppose? It does not have to be this way.

We can take significant steps to address health care—steps guided by principles based on the freedom of choice, transparency and openness, and a competitive free market.

We can lower health care premiums for American families and small businesses, addressing Americans' number-one priority for health care reform.

We can establish a universal access program to guarantee access to affordable health care for people with pre-existing conditions. The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to ''junk lawsuits.'' The fear of lawsuits drives doctors to order expensive tests and procedures for patients, and not necessarily because they think they are in the best interest of the patients. Some doctors have even had to close their doors because they cannot afford the malpractice insurance premiums. It is evident that meaningful medical malpractice reform should be a component of any health care reform proposal. The Republican plan would help save $54 billion in the health care sector by including measures that have been successfully demonstrated in California and Texas.

Just as we all want to reduce the cost of care, we should seek innovative ways to provide coverage without breaking the bank. We can do this by empowering small businesses with the opportunity to pool together and negotiate lower health care premiums—just as corporations and labor unions do—through association health plans. Another common sense reform would allow Americans to shop for coverage from coast to coast across state lines.

We can promote prevention and wellness by giving employers greater flexibility to financially reward employees who adopt healthier lifestyles. Incidentally, about 75 percent of medical spending goes toward the treatment of chronic diseases. Research shows that the number of individuals suffering from chronic diseases like diabetes and heart disease could be reduced through proper wellness, prevention, and disease management programs. The Republican alternative would allow for employers to offer flexible coverage options to reward and encourage healthy behaviors in an effort to reduce overall spending on costly chronic diseases.

We can do all of these things and more, Mr. Speaker. And we can do these things with legislation that the Congressional Budget Office says will lower premiums by up to 10 percent and reduce the deficit by $68 billion over the next ten years, without imposing tax increases on families and small businesses.

This alternative will give Americans access to health care, it will free up our medical system to become more innovative and efficient, and it is what Americans expect from their country.

Mr. Speaker, this alternative is what this Congress should be sending to the President's desk—not the mammoth, unwise, and extraordinary expansion of government embodied in H.R. 3962.

I urge my colleagues to vote ''no'' on this bill.

Ms. JENKINS. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn't destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bipartisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. While the innovator's have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators' products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should be occurring in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. CONAWAY. Mr. Speaker, I have criticized many of the provisions of H.R. 3962, the Affordable Health Care for America Act, and with good reason. However, I believe that the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that does not destroy the ability or the incentives for innovator companies to develop breakthrough technology and at the same time provide a safe and effective way to bring competition to benefit patients is a creditable achievement. Ideally, this provision would be removed from this fatally flawed piece of legislation and considered separately, as it would pass with overwhelming bipartisan support.

These provisions are the first step on the long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA must write rules that will ensure that research is done safely and effectively. I have long supported the U.S. biotechnology industry as it has been a strong engine of job creation in this country. Unfortunately, many larger companies that seek to enter the biosimilar market have outsourced research to foreign countries. With this week's devastating news that unemployment has reached 10.2 percent, it is critical that we preserve jobs in the United States.

As this new market launches in the United States, we must foster innovative products at home to create jobs, and conduct research that will prove whether products are interchangeable with innovators' products. It is unlikely that these companies can create such interchangeable products; however research and testing will prove if it can be conducted within our borders without being outsourced.

Mr. EHLERS. Mr. Speaker, on November 14, 2009, Northrop Grumman will lay the keel of the first ship of the new *Gerald R. Ford* class of nuclear-powered aircraft carriers, the U.S.S. *Gerald R. Ford* (CVN–78), in Newport News, Virginia. Susan Ford Bales, the daughter of President Ford, is the ship's sponsor and will serve as the keel authenticator for the ceremony.

President Ford was a good friend of mine, and I am honored to hold his former seat in the U.S. House of Representatives. In 2006, I supported an amendment to the 2007 national defense authorization bill, offered by then Senator John Warner, which expressed the sense of Congress that the CVN–78 should be named after President Gerald R. Ford. On January 16, 2007, the U.S. Navy followed Congress's instruction and announced that CVN–78 would be so named. Consequently, CVN–78 and other carriers built to the same design all will be referred to as ''*Ford* class carriers.''

The *Gerald R. Ford* class carrier design is the successor to the *Nimitz* class design, and it incorporates several improvements, such as allowing more sorties per day and requiring fewer sailors for its operations and maintenance. Expected to enter into service in 2015, the U.S.S. *Gerald Ford*, and its *Ford* class successors, will ensure that the U.S. Navy, and policymakers, will continue to have the assets they need to adequately defend our nation and protect our allies and interests around the globe.

President Ford served his country honorably and faithfully for more than 60 years, first as a Navy officer during World War II, then as a Congressman, Vice President and finally as President and former President. I believe it is fitting that we name this next class of aircraft carriers after President Ford, and I look forward to monitoring the future success of the U.S.S. *Ford*.

Mr. HONDA. Mr. Speaker, in our lives as public servants, Members of Congress are rarely presented with opportunities to support the passage of truly historic legislation. Today is such a day, and this health care vote such an opportunity. Over the past ten months that I have participated in the creation of this health reform bill, I have been thinking about the words of Hubert Humphrey: ''It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.''

Today I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. For 70 years Americans have been waiting for this moment. I would like to particularly thank Speaker PELOSI for her deft leadership and management of a complex policy debate, Majority Leader HOYER, Majority Whip CLYBURN, the Chairs of the Committees on Energy and Commerce, Education and Labor, and Ways and Means, along with my fellow progressive and colleagues in the Congressional Asian Pacific American Caucus, Congressional Black Caucus, and Congressional Hispanic Caucus (collectively known as the TriCaucus) for their public and private commitments to preserve the public option. Finally, I commend staff of all the committees for their hard work and commitment to this issue.

Against an organized, scorched earth campaign of misinformation and fear mongering, we are emerging with a strong bill, and an even stronger sense of unity and purpose in our fight to bring access, affordability, and high quality health care to every person in America. If the best of our reforms prevail, insurance companies will no longer be able to subject people to complex, confusing policy details, lifetime and annual limits, or denials based on pre-existing conditions. American taxpayers will save over $100 billion in the first decade and will experience significant improvements in our health care system.

Although I have strenuously supported a stronger public option, I recognize that the balance of improvements made to the health care system as a whole through the reforms in this bill is substantial. When some thought the public option was dead, I and my other colleagues rallied to bring it back into the discussion and succeeded in keeping the public option in the final bill. The public option is a cornerstone of the effort to bend the cost curve in health care and must be preserved.

In my district alone, H.R. 2692 will improve employer based coverage for 500,000 residents, allow 16,700 small businesses to obtain affordable health care coverage and provide coverage for 28,000 uninsured residents. Finally, in a time of increasing pressure on local governments, it will reduce the cost of uncompensated care for hospitals and health care providers by $205 million. It will protect the seniors in my district from the doughnut hole and improve the quality of their Medicare coverage.

As Chairman of the Congressional Asian Pacific American Caucus, I am particularly encouraged by the inclusion of legislative language addressing racial and ethnic health disparities. As members of the TriCaucus, we have long been advocating on the issue of health disparities and I am proud of the impact we have had in making changes that will directly help the poorest and most disadvantaged communities. across this nation. As a long-time supporter of Native Americans in their struggle to survive and thrive after hundreds of years of oppression and genocide, I am particularly pleased by the inclusion of the Indian Comprehensive Health Insurance Act in

health care reform. Native American communities worked for over a decade to come together and write policy that would help their communities begin to address the terrible and tragic health disparities they experience and the inclusion of ICHIA is a step in the right direction by the Federal Government to rectify some of the imbalances and abuses that they have caused in Native communities.

Despite the many extraordinary improvements to many aspects of our healthcare system, including an unprecedented expansion of access to Medicaid for many poor families, I am dismayed that we were not able to lift the 5 year bar on legal immigrant participation in Medicaid. Legal immigrants are tax paying citizens in waiting who work hard and contribute. It is only fair that we afford them equal access to the benefits of Medicaid. I will continue to advocate on this issue in the future and I know that I am joined in my concern by many of my colleagues.

Americans live in the wealthiest, most powerful nation in the world and spend $2 trillion a year on health care every year—more than the national budget of China—and yet we don't have the best health care in the world. Thousands suffer and many die because of a lack of access to health care. Passing this bill and preserving its structure is a critical investment in the health of future generations.

Mr. CALVERT. Mr. Speaker, I rise today in objection to the Pelosi Health Care Bill which creates over $1 trillion in new government spending. It is funded with the ''Hope'' that our children will figure out how to pay the bill tomorrow and with a ''Change'' in the Medicare program that cuts $500 billion from the over 45 million beneficiaries currently covered.

Provisions within the Pelosi Health Reform Bill will raise premiums and lower access to care for America's seniors. Although Democrats try to present these changes to Medicare as improvements and savings, the White House's own actuaries have stated that these changes will increase Medicare spending at a greater rate than if we had done nothing at all. With the Centers for Medicare and Medicaid Services reporting earlier this year that the Medicare trust fund will be exhausted by 2017, I do not believe this Congress should take any action that hastens the jeopardy already faced by America's seniors.

The Pelosi Health Care Bill cuts $170 billion from the Medicare Advantage Program, which covers almost 50 percent of the Medicare beneficiaries in the 44th Congressional District of California—36,124 senior citizens who rely on this highly successful program for their health care needs. The cuts undermine a program that currently gives seniors the choice to enroll in a private option and that provides the same benefits as traditional Medicare, prescription drug and other additional health benefits, usually with lower copayments.

The proposed changes also will result in reduced benefits for Medicare Advantage beneficiaries or result in higher premiums and copayments for fixed income seniors. But let me be clear—not for an improvement in service, but for the same or reduced level of service. For the workforce paying into the Medicare program, higher taxes are ahead.

In addition to the increased tax burden working Americans will face to keep Medicare afloat, this bill levies a 2.5 percent tax on the incomes of hardworking working Americans who cannot afford insurance. This breaks a fundamental promise of President Obama's campaign that he would not raise taxes on the middle class.

And even as the national unemployment climbs above 10 percent nationwide—over 20 percent in some parts of my district—Speaker PELOSI seeks to place an 8 percent tax on small businesses who cannot afford to provide government mandated ''acceptable insurance'' to their employees. In this economic climate, Congress should be working to enact real reform across the United States that creates jobs and stimulates the economy, not enacting a government expansion and tax regime that will put the jobs of at least 5.5 million largely low wage earners, minorities and young people at risk.

Finally, while Americans struggle to pay their bills and put food on the table, Speaker PELOSI wants even more of their tax dollars to be spent to provide federal health benefits to the 12 million illegal immigrants currently in the United States. As I understand the bill before us today, a person would only need to ''declare'' that they are a citizen, provide a name and Social Security number and they would be eligible to receive health insurance benefits. There is no requirement for the verification of identification documentation. It is absolutely unacceptable that this bill would not, at a minimum, require even one verified identification document in order to receive taxpayer funded health care benefits. The bill should include clear processes and require documentation to confirm that an individual applying for health care benefits is a citizen or legal resident of the United States like the E-Verify program I created in 1996 for employers to verify the legal status of new employees.

The crafting of the bill before us today spent American liberties to purchase House Democrat votes in order to secure a political victory. The resulting legislation has put freedom and American ingenuity under the knife. For the sake of American jobs, American families and future generations, we must kill this bill and resume our work to create jobs, rein in government spending, increase healthcare freedom and choice and getting the U.S. government's financial house back in order.

However, I look forward to voting in favor of the Stupak-Pitts Amendment, which maintains the current federal government policy of preventing federal funding for abortion and for benefits packages that include abortion. This amendment ensures that federal taxpayers will not be coerced into funding elective abortions and is supported by U.S. Conference of Catholic Bishops, Democrats for Life, National Right to Life, Americans United for Life, Family Research Council, Concerned Women for America and many other pro-life groups. I look forward to continuing to work to ensure taxpayer funds are not used to fund abortions and to provide the broadest possible conscience protections for physicians, health professionals, hospitals, insurers, and all those in the business of caring for the health of Americans.

Mr. DICKS. Mr. Speaker, we have reached a pivotal moment in the House of Representatives today as we are about to approve the most significant expansion of access to health care in America in at least a generation. And the bill we are about to approve also represents the most substantial improvement of the quality of health care in our country that has been passed in the entire time I have been in Congress. I am proud to support this long-overdue and aptly-named legislation, the Affordable Health Care for America Act.

I am particularly pleased that we have come to an agreement within this bill on a provision that I believe will lead to a dramatic improvement in the way we pay for health care for America's seniors under Medicare. Under the current Medicare payment system, providers are reimbursed on a ''fee-for-service'' system that encourages more procedures and office visits. One of the most encouraging aspects of H.R. 3962 is language that will help shift Medicare to a system that is more efficient and that encourages better coordination of health care for seniors.

Medicare's complex reimbursement formula has long punished doctors for providing more cost effective, quality health care. It is truly unfair under our current system that Medicare spends $7,363 per enrollee in a city in my district—Tacoma, Washington—while it spends twice that amount, $14,946, in the small Texas town of McAllen. These differences are largely due to discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources—and a payment system that rewards growth and more intense use of medical facilities and testing. But this focus on utilization is not only inherently more costly, it tends to ignore the health care outcomes, which should really be the goal of any system of care. And it exacerbates the problem we are already facing with Medicare: out-of-control growth rates. At current trajectory, Medicare will be $660 billion in the red by 2023, highlighting the urgent need to find ways to trim this growth rate. If we could reduce the annual growth in per capita Medicare spending from the national average—3.5 percent—to 2.4 percent, the rate in San Francisco, Medicare could save $1.42 trillion over that period and turn the deficit into a healthy surplus.

So in order to help move us toward this goal and produce a more equitable system of reimbursement, I was pleased to work with a number of concerned Members here in Congress on language in this bill that will enlist the resources of the independent, non-profit Institute of Medicine to examine the existing Medicare geographic payment inequities for both physician and hospital payments and to address the inequities that are clearly contained in our current system. We are also investing $4 billion per year in 2012 and 2013 to make payment rate adjustments so that no geographic area will be disadvantaged during 2012 and 2013.

I am also pleased that a related provision of this bill calls for an additional study by the Institute of Medicine to conceptualize a system of Medicare payments based on quality outcomes versus the current system of ''fee-for-service.'' This ''High-Value Study'' will be completed by April 15, 2011 and the Institute's recommendations will be submitted to the Secretary of Health and Human Services, who will then have 240 days to submit a final implementation plan to Congress. This plan will take effect unless Congress passes a resolution of disapproval by the end of May 2012.

These are very important reforms that I believe will help ensure the solvency of Medicare and promote a more equitable system of health care for seniors that stresses results over process. They are among the many aspects of this overall health care reform package that deserve our support, and I am proud

to be speaking today to recognize these provisions and to urge all my colleagues to pass the Affordable Health Care for America Act.

Mr. WALZ. Mr. Speaker, over the past three years, I've discussed health care reform with thousands of my constituents. I've heard from doctors and nurses, health care policy experts and small business owners. Most importantly, I've heard from middle-class Minnesotans who are fed up with the status quo.

Take Kristy, who is a Rochester mother and breast cancer survivor. Access to affordable health insurance is a life or death matter for her and millions of other Americans.

Last year, Kristy's health insurance premium increased 17 percent. Hard-working Americans every year see premiums rise faster than their take-home pay. This is a financial disaster in progress. If ignored, this will result in an explosion in the number of uninsured individuals, reaching far into the ranks of the gainfully employed and middle class.

Kristy's employer laid-off workers this year, in part because of rapidly rising health care costs. Small businesses across America are shedding good workers to cover sky-rocketing health care expenses, stifling entrepreneurship and innovation.

And then, recently, Kristy lost her job. She worries about whether she'll be able to get health insurance given her pre-existing medical condition, once her temporary COBRA coverage expires.

Last year, more than 700 of our neighbors in southern Minnesota went bankrupt because of medical bills. It is unconscionable for anyone to go broke solely because they get sick. Now, Kristy wonders if she's next.

Kristy's story has become all too common in America today.

It doesn't have to be this way.

I rise today in strong support of H.R. 3962, the Affordable Health Care for America Act, because of people like Kristy. This bill, which includes important fixes from Democrats and Republicans, will tear down the status quo, rein in costs and bring stability and peace of mind to regular people like Kristy.

The House health care bill has four important pillars of reform:

The first pillar stops run-away costs and rewards quality care. A patient-centered initiative spearheaded by Mayo Clinic is at the heart of rewarding quality. The current fee-for-service payment model in Medicare perversely encourages health care providers to perform unnecessary procedures and tests. This is backwards. Hospitals and doctors should instead be rewarded for innovation, results, and quality care. The Mayo-backed solution in this bill asks experts at the independent Institute of Medicine to come up with and help implement new pay-for-results policy in Medicare. This will help deliver better care for our seniors.

The second pillar reforms the insurance industry to benefit ordinary folks. It provides overdue transparency and accountability by ending health insurance companies' blanket exemption from anti-trust laws. Firms will no longer be shielded from liability for price-fixing or monopolizing. We've seen what happened on Wall Street when corporations got too big to fail and their books too confusing to understand.

It goes further to protect consumers by making it illegal to deny coverage for pre-existing conditions like Kristy's or charging more based on gender, occupation, or health status. It also caps annual out-of-pocket expenses and prohibits unfair limits on benefits to ensure no American goes bankrupt because of illness. And, it allows individuals up to the age of 27 to stay on their parents' insurance plan.

The third pillar promotes competition and choice for people who don't have insurance today or lose it in the future. Under the bill, Americans will be required to obtain health insurance, just like drivers are mandated by state law to purchase auto insurance.

People who don't have health insurance today or lose it in the future can participate in the Health Insurance Exchange where they can compare and purchase insurance products that best meets their needs. An analysis by MIT Economist Jonathan Gruber found that premiums for folks in the Exchange will be lower than they would be if those same people were buying individual insurance in today's market.

Privately-owned insurance companies, member-owned cooperatives, and a government-backed public option will compete for business in the Exchange. Low-income workers will get financial credits to help them afford to buy insurance.

Another solution brought up at my town hall meetings and championed by Minnesota's Republican Governor Tim Pawlenty is fostering competition and lower costs through interstate insurance sales. The House health care bill allows states to work together to do just that.

Finally, the fourth pillar will improve seniors' access to quality, affordable health care and protect the doctor-patient relationship. It addresses one of seniors' top concerns by immediately beginning to fill in the Medicare Part D donut hole which will make prescription drugs more affordable.

I joined the President and Republicans in demanding that health care reform be fiscally responsible. The bill before us now is paid for and does not add to the national debt, according to the nonpartisan Congressional Budget Office.

To the defenders of the status quo who are opposing health insurance reform, I have one question for you: How does your plan help people like Kristy?

I encourage my colleagues to stop playing political games and come together across party lines to solve the problem. Vote yes on H.R. 3962, the Affordable Health Care for America Act.

Mr. MANZULLO. Mr. Speaker, America's health care system is in need of reform. The families in the congressional district I represent have seen their health premiums consume more and more of their salary. Employers are faced with the difficult decision regarding whether or not they can continue to afford to offer their employees the health coverage they know they need. Many more wish they could offer their employees coverage but the orders just aren't there, not in this economy. Doctors and other health providers have seen their reimbursements decline while their practice costs have risen and their liability insurance premiums have skyrocketed due to those who abuse our lawsuit system. Some doctors have reached the conclusion that they can no longer accept Medicare or Medicaid patients.

I have spent my entire tenure in Congress working to reform our health care system to help these families, employers, and health providers. I have worked to pass association health plans so that small businesses can join together with other small businesses from across the country to grow their purchasing power on behalf their employees. I have also supported allowing Americans to obtain health insurance through other larger purchasing pools such as their church denomination, alumni association or other memberships. The Republican Congress twice passed association health plans only to come up short as a result of Democrat opposition in the Senate.

I have worked to pass health care options that meet the unique needs of families, such as medical savings accounts, health savings accounts, and flexible spending arrangements. These important initiatives allow families to save for future health needs and have been an important tool for small businesses. However, I have also had to defend these successful plans from assault by those who seek sources of revenue to fund tried-and-failed big government programs.

I have worked to pass medical liability reform to reduce the high premiums that are driving doctors and other health providers from practice. Doctors in the district I represent face medical liability premiums three to four times as high as their colleagues just north of the border in Wisconsin as a result of Wisconsin's sensible cap on the third-layer non-economic, punitive awards. The Republican Congress twice passed medical liability reform only to have the reform die in the Senate as a result of Democrat opposition.

I have worked to revise the flawed payment formula for doctors who treat Medicare patients to ensure that our seniors continue to have timely access to the most talented medical professionals in our community. I have worked to make sure that none of our health providers are targeted unfairly by government policies or agencies.

And I have spent over 75 percent of my time trying to improve the economic climate for the manufacturers and other small businesses back home so that they can not only remain competitive world-wide, but also be able to offer competitive health care benefits for their employees.

Today, I support a Republican plan that continues to pursue these important reforms. Rather than punish small businesses with onerous mandates and tax penalties for not offering health coverage, the Republican plan will provide tools for small businesses to pool together, just as larger corporations or labor unions do, to offer health care to their employees at lower prices.

The Republican plan would save $54 billion by helping to restore common sense to the legal system and curb defensive medicine by enacting medical liability reforms modeled after the successful state laws of California and Texas. This will dramatically reduce health costs for doctors and patients and will reduce the need for expensive additional tests or procedures that do nothing to improve health status but simply are ordered because of the threats of lawsuits.

The Republican plan will lower health insurance premiums for all Americans. The nonpartisan Congressional Budget Office estimated that premiums would be reduced by 10 percent for employees who receive their coverage through their small business employer; 8 percent for those who do not have access to employer-provided coverage; and 3 percent for employees who receive their coverage through a larger business. Families will see

their premiums $5,000 lower than the cheapest government run health insurance plan offered by the Democrats.

The Republican plan provides options for those with pre-existing conditions or those otherwise unable to afford health insurance through state high risk pool options designed to meet the unique regional needs of local citizens. The Republican plan provides options for young adults to remain on their parents' health plans.

The Republican plan promotes innovation in the areas of coverage, technology, and wellness, and prevents government bureaucrats from coming between a doctor and patient. It preserves existing law preventing federal funding from paying for elective abortions. It doesn't raise taxes; it doesn't cut Medicare benefits; it doesn't force anyone into a new government-run health program; and rather than increasing the debt burden on our children and grandchildren, the CBO estimates that the Republican plan will save $68 billion over the next ten years.

Unfortunately, the bill offered by House Speaker NANCY PELOSI (D–CA) takes a very different approach. The Pelosi bill is a $1.3 trillion dollar federal government takeover of the entire health care sector. It increases taxes by $766 billion, taken from badly needed capital for operations and loans for small businesses and is estimated to kill 5.5 million jobs. It penalizes employers for not offering and employees for not purchasing the health coverage that a new all-powerful Health Choices Commissioner deems acceptable. It increases the cost of health care for patients and other health consumers through a new 2.5 percent tax on medical equipment, such as wheel chairs. The Pelosi plan cuts $500 billion from Medicare, which will hurt 18,425 seniors from the Congressional district I represent. District hospitals will see their Medicare payments cut by $244.7 million and local skilled nursing facilities will lose $113.4 million.

Despite claiming the goal of decreasing health costs, the Democrat bill creates 111 new bureaucracies, commissions, agencies, or offices, necessitating the hiring of thousands of new bureaucrats. These new czars and commissars will micromanage all aspects of Americans' health, including the following from page 1514: ''The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.''

This Pelosi bill irresponsibly shifts significant costs to the states by hiking their Medicaid expenses. Most states already face significant existing Medicaid shortfalls as demonstrated by the Medicaid bailout for states contained in the Democrat stimulus bill.

The creation of a new government health insurance exchange through which all insurance must be approved and through which all individual insurance must be sold will jeopardize the insurance choices currently enjoyed by over 85 percent of Americans. The creation of a government run health insurance plan coupled with a heavy-fisted regulatory scheme tipped significantly in its favor will further erode the Americans choice of coverage and eventually result in most Americans being forced into a full-blown government run insurance scheme. Further troubling is the inclusion of comparative effectiveness research panels that are utilized in European single-payer systems to ration health care based on cost factors.

And despite the CBO's estimate on the significant savings that could be achieved, the Democrat bill not only contains no medical liability reform, but it actually incentivizes states to repeal their existing medical liability laws in exchange for money.

In sum, the Pelosi bill will kill jobs, cut Medicare, pile debt on our children, increase health care costs, ration care, and raise taxes. As a result of these and hundreds of other disturbing provisions, I cannot in good conscience vote for the Pelosi government takeover of health care.

Ms. KAPTUR. Mr. speaker the Affordable Health Care for America Act will strengthen America and offer greater security to our workers, families, seniors and businesses. It will enhance our nation's health care system, placing American healthcare consumers where they belong: at the heart of it. H.R. 3962 will improve quality, choice and competition, while cutting down fraud, waste and abuse, and lowering costs over the long term. It will strengthen Medicare, eliminate the Part D ''donut hole,'' improve access for lower income citizens so that Medicare is affordable for ALL seniors, and create new consumer protections for Medicare Advantage Plans. Discrimination for pre-existing conditions, dropped coverage, and yearly or lifetime caps will no longer be tolerated. Co-pays and other cost-sharing for preventative services will be eliminated and annual caps on what an individual or a family pays out-of-pocket will be established.

Since 1987, the cost of the average family health insurance policy has risen from 7 percent of median family income to 17 percent. Family premiums are projected to increase an average of $1,800 each year and in 2007, 60 percent of bankruptcies were reported to be related to medical costs. With this bill, no American family will go bankrupt because they get sick.

Sixty percent of our nation's entire uninsured population are small business owners and their employees and families. This equals at least 28 to million uninsured Americans. Small business premiums have risen 129 percent since 2000. In 2008, 38 percent of small companies offered health coverage, compared with 41 percent in 2007 and 61 percent in 1993.

For too long, the health of our nation has dwindled while the pockets of the insurance giants have thickened. Our seniors have compromised prescription drugs for necessary groceries, while the pharmaceutical industry has made record profits. Hard working families have watched their savings plummet and their homes foreclosed after unexpected illnesses. Woman with breast cancer, men with heart disease and children with leukemia or childhood diabetes have been flat-out denied health insurance coverage for pre-existing conditions or reaching insurance policy caps.

Under the House Plan, the Ninth Congressional District of Ohio will benefit immensely and in very specific ways:

386,000 residents in the region I represent will see improved employer-based coverage.

167,000 households would be eligible for credits to help pay for coverage.

38,000 uninsured citizens just in our region would be eligible for insurance under a reformed system.

14,500 small businesses will be allowed to obtain affordable health care coverage and 12,400 among them will receive tax credits to help reduce the costs of health insurance.

102,000 beneficiaries will benefit from an improved Medicare program.

7,600 seniors will benefit from closing the prescription drug donut hole, starting with $500 of cost forgiveness is 2010.

1,700 families will be protected from bankruptcy due to unaffordable health care costs.

$120 million in savings will be seen by hospitals and health care providers as a result of reductions in uncompensated care.

The uninsured will receive immediate relieve through a temporary insurance program. Individuals receiving COBRA will be allowed to keep their coverage until a more customer friendly, one-stop marketplace for health insurance, known as the Exchange, is created. The Exchange will offer affordability credits and tax credits for individuals and businesses that need them. Health plans will be required to allow young people until their 27th birthday to remain on their parents' health insurance policy. Moreover, insurance companies will be subject to public review and disclosure of insurance excessive rate increases.

Much needed investments will be made right away in training programs designed to increase the number of primary care doctors, nurses, and public health professionals. Not-for-Profit purchasing collaboratives, such as the FrontPath Health Coalition from Northwest Ohio, will be strengthened to achieve careful plan management and cost-savings, and encouraged as a central provision of Title I. Community Health Centers will see an increase in funding to allow for a doubling of patients over the next 5 years. A $10 billion fund will be created to finance a temporary reinsurance program to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55–64.

The well being of individuals and our nation will benefit from these reforms. From an economic standpoint, healthcare costs have stifled the vitality of American businesses and their ability to compete in the global marketplace. The 129 percent increase since 2000 in small business premiums alone have smothered their potential and destroyed their ability to cover employees, resulting in an astounding 60 percent of our nation's entire uninsured population.

Affordable health insurance reform is necessary to cut the costs of doing business, reduce the share of government expenditures spent on health care, help our companies to be more competitive in the world market, unleash the entrepreneurial talents of the American people, and give peace of mind to the middle class and our seniors and others that everything they have worked for will not be taken away if they get sick.

As someone who grew up in a small business family, I watched our father forced to sell our small family grocery when he became ill. He needed health insurance for our family and took a job at a local auto assembly plant to obtain it for his wife and children. I promised myself when I was elected to Congress that passing legislation to cover small business would be one of my top priorities. Finally, it has become possible to vote on a bill that will do this for millions of our fellow citizens.

With the mounting economic strain on American families and the rising costs of health insurance to workers, businesses and federal budget, the status quo has proven itself unsustainable, fiscally irresponsible and morally unacceptable. The time has come for this historical change. I stand in support of its promise to the American people.

Mr. KUCINICH. Mr. Speaker, we have been led to believe that we must make our health care choices only within the current structure of a predatory, for-profit insurance system which makes money not providing health care. We cannot fault the insurance companies for being what they are. But we can fault legislation in which the government incentivizes the perpetuation, indeed the strengthening, of the for-profit health insurance industry, the very source of the problem. When health insurance companies deny care or raise premiums, copays and deductibles they are simply trying to make a profit. That is our system.

Clearly, the insurance companies are the problem, not the solution. They are driving up the cost of health care. Because their massive bureaucracy avoids paying bills so effectively, they force hospitals and doctors to hire their own bureaucracy to fight the insurance companies to avoid getting stuck with an unfair share of the bills. The result is that since 1970, the number of physicians has increased by less than 200% while the number of administrators has increased by 3000%. It is no wonder that 31 cents of every health care dollar goes to administrative costs, not toward providing care. Even those with insurance are at risk. The single biggest cause of bankruptcies in the U.S. is health insurance policies that do not cover you when you get sick.

But instead of working toward the elimination of for-profit insurance, H.R. 3962 would put the government in the role of accelerating the privatization of health care. In H.R. 3962, the government is requiring at least 21 million Americans to buy private health insurance from the very industry that causes costs to be so high, which will result in at least $70 billion in new annual revenue, much of which is coming from taxpayers. This inevitably will lead to even more cost, more subsidies, and higher profits for insurance companies—a bailout under a blue cross.

By incurring only a new requirement to cover pre-existing conditions, a weakened public option, and a few other important but limited concessions, the health insurance companies are getting quite a deal. The Center for American Progress' blog, Think Progress, states ''since the President signaled that he is backing away from the public option, health insurance stocks have been on the rise.'' Similarly, healthcare stocks rallied when Senator MAX BAUCUS introduced a bill without a public option. Bloomberg reports that Curtis Lane, a prominent health industry investor, predicted a few weeks ago that ''money will start flowing in again'' to health insurance stocks after passage of the legislation. Investors.com last month reported that pharmacy benefit managers share prices are hitting all-time highs, with the only industry worry that the Administration would reverse its decision not to negotiate Medicare Part D drug prices, leaving in place a Bush Administration policy.

During the debate, when the interests of insurance companies would have been effectively challenged, that challenge was turned back. The ''robust public option'' which would have offered a modicum of competition to a monopolistic industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administration. Looking ahead, we cringe at the prospect of even greater favors for insurance companies.

Recent rises in unemployment indicate a widening separation between the finance economy and the real economy. The finance economy considers the health of Wall Street, rising corporate profits, and banks' hoarding of cash, much of it from taxpayers, as sign of an economic recovery. However in the real economy—in which most Americans live—the recession is not over. Rising unemployment, business failures, bankruptcies and foreclosures are still hammering Main Street.

This health care bill continues the redistribution of wealth to Wall Street at the expense of America's manufacturing and service economies which suffer from costs other countries do not have to bear, especially the cost of health care. America continues to stand out among all industrialized nations for its privatized health care system. As a result, we are less competitive in steel, automotive, aerospace and shipping while other countries subsidize their exports in these areas through socializing the cost of health care.

Notwithstanding the fate of H.R. 3962, America will someday come to recognize the broad social and economic benefits of a not-for-profit, single-payer health care system, which is good for the American people and good for America's businesses, with of course the notable exceptions being insurance and pharmaceuticals.

Mr. AL GREEN of Texas. Mr. Speaker, I rise in support of H.R. 3962, the Affordable Healthcare for America Act. I would like to thank the Democratic Leadership and the Chairmen of the committees of jurisdiction for their unwavering commitment to this important cause.

Today, we are faced with a historic opportunity to accomplish meaningful change in the lives of millions of Americans. I am in support of this bill because I believe in improving the quality of care, the accessibility of care, and the affordability of care. The status quo is unsustainable and the cost of inaction is simply too high.

If we pass this legislation, we will reduce the federal deficit by an estimated $129 billion over the next ten years. If we fail to do so, we will ensure that our country continues to spend $79,274 a second on healthcare. We will continue to dedicate 17.6 percent of our gross domestic product, or $2.5 trillion a year towards healthcare expenditures.

To pass this legislation would mean that an estimated 36 million Americans would gain access to health insurance; failing to do so, would mean that the 45.7 million Americans who cannot afford, or cannot gain access to healthcare, would remain without coverage. Among the 45.7 million uninsured, 1.4 million are children in my home state of Texas—this is simply unacceptable.

Finally, passing this legislation would mean an end to the discriminatory practices of the health insurance industry that have devastated so many Americans. No longer will people fear having a pre-existing condition will prevent them from receiving health insurance coverage. No longer will families fear the uncertainty of a catastrophic health event, or fear being driven into bankruptcy in trying to pay for the cost of care. No longer will people have to fear losing their health coverage simply for getting sick. In passing this legislation, we put an end to the days when 14,000 Americans lose their coverage every day.

The time has come when we, in Congress, are faced with a decision to either change the course of this country, to shift its direction towards accessible and affordable healthcare, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.

Mr. MARKEY. Mr. Speaker, thank you Speaker PELOSI, Chairman WAXMAN, Chairman Emeritus DINGELL, Chairman RANGEL and Chairman MILLER for your leadership in bringing us to this historic day.

For almost a century, we have been laying the groundwork for comprehensive health care reform in our country—ever since Theodore Roosevelt's Progressive Party included health insurance coverage in its platform for the 1912 elections.

Since then, there has been some progress—Medicare for seniors, Medicaid for the poor, CHIP for children,—as well as successful efforts in some states, including the landmark health reform law enacted in my home state of Massachusetts three years ago. But we have continued to come up short. And now the 46 million Americans without health care are paying the price.

Our health care system has been ailing for decades, and now it's in intensive care. The consequences of this broken health care system are severe—the number one cause of personal bankruptcies today is medical bills—Americans going broke when they get sick. And 80 percent of these medical bankruptcies strike Americans who actually have insurance. It is unconscionable that so many Americans have to fight their insurance companies while they fight for their very lives. Their insurance policies fail to cover all of the astronomical costs associated with their treatment. They are insured, but not covered.

I recently received a letter from a constituent that illustrates one of the reasons why we need health care reform now. Peter returned home from the hospital to find a bill informing him that his insurance company denied coverage for the anesthesia used during his operation. The insurance company deemed the anesthesia ''medically unnecessary'' and billed him $10,000.

He had open heart surgery, Mr. Chairman. So he asked me, did the insurance company expect him to ''take a swig of whiskey and bite a bullet'' while the surgeon cut open his chest? Unbelievable, Mr. Chairman, but true. Like too many Americans, he was insured, but not covered. We desperately need health care reform because there are too many stories like Pete's all across the country.

My Republican colleagues want to put a Band-Aid on our badly broken system, but what it really needs is CPR—Coverage, Prevention and Research. That's exactly what our health bill delivers for the American people.

We expand COVERAGE to ensure that all Americans have access to affordable care.

We invest in PREVENTION to transform our system from a ''sick care'' system into a true health care system.

We support RESEARCH, building on the $10.4 billion down payment in the recovery and reinvestment act for NIH. In this bill, we will invest in comparative effectiveness research to help improve the quality of care and reduce costs.

The Republicans' plan is really quite simple: You're On Your Own. The Republican plan tells Americans—''If you get sick and don't have insurance, you're on your own.'' The Republican plan tells Americans if you are denied coverage because of a pre-existing condition ''You're on your own.'' Republican Leaders in Washington seem to be suffering from a pre-existing condition of their own—a heart of stone. If you kicked their heart, you'd break your toe! And under the Republican plan, they could be denied coverage.

The Republicans say the Democratic Plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill, not the Republican Plan. They say it will hurt small businesses but the Main Street Alliance, representing thousands of small businesses around the country, support the Democratic bill, not the Republican Plan. The Republicans claim the Democratic bill will hurt seniors, but the AARP has endorsed the Democratic bill, not the Republican Plan.

There are reasons why the AARP supports the Democratic bill. The Democratic bill will close the Medicare part D donut hole, the Republican bill does not. We provide support for low-income seniors, they do not. We will extend the solvency of Medicare, they do not.

You know, GOP used to stand for Grand Old Party. Now it stands for Grandstand, Oppose, and Pretend. They grandstand with phony claims about non-existent death panels. They oppose any real reform. And with this Substitute they pretend to offer a solution while really doing nothing. GOP—Grandstand, Oppose, and Pretend.

Make no mistake about it; the Republican substitute is not real reform. It does nothing to curb skyrocketing health care costs. It does nothing to provide real insurance coverage to millions who are now uninsured. It does nothing to stop the unfair practices of insurance companies.

Mr. Speaker, there are too many Americans living in fear of a terrorist attack, but not the kind that comes from a gunshot, bomb or box cutter. It's the kind that may strike during a phone call from the doctor's office or during a check-up when the doctor delivers devastating news: ''You have cancer''; ''Your memory loss is early onset Alzheimer's''; ''The numbness is Parkinson's''; ''The Lou Gehrig's Disease that claimed your grandfather will strike you one day.''

We can fight against the terror of disease by reforming our health care system with better coordination, focusing on prevention, and ensuring that all Americans have access to quality, affordable care. And that's exactly what our bill will do.

I am pleased that this historic bill includes provisions that I authored, including:

A Medicare program to provide coordinated care to severely ill patients by a team of doctors and other health care professionals right in the beneficiaries' own homes, allowing these frail Americans to remain independent as long as possible.

A provision to allow patients with rare diseases, like cystic fibrosis, to participate in clinical trial research to find a cure for their devastating disease without losing eligibility for the Social Security benefits they depend on.

A safeguard to ensure that insurance companies don't game the new health care exchange by cherry-picking only healthy individuals.

Today, we are here to write a new chapter in our century-long effort to provide every American with the health care coverage they need and deserve.

Today we can vote for a bill that uses the American values of choice, innovation, and competition to address some of our nation's greatest challenges—skyrocketing health care costs, millions without health insurance, and millions more who are under-insured and struggling to pay their medical bills.

Today we can pass legislation that gives all Americans access to quality, affordable health care. I urge my colleagues to vote ''aye'' on this bill.

Ms. HERSETH SANDLIN. Mr. Speaker, I believe it's critical that we control rising health care costs, increase quality and value within our health care system, and that we improve access to health care and affordable health care insurance coverage.

H.R. 3962, the Affordable Health Care for America Act, represents one of the most important votes of the year, on an issue that has been a priority for me since I first was given the honor of representing South Dakotans in Congress. I have long believed that the strength of our communities in South Dakota depends on the health of our people and that, unfortunately, quality, affordable care remains out of reach for far too many South Dakotans.

I am convinced this Congress and the President will achieve fundamental reform because our country must fix what's broken in our health care system. The status quo is unsustainable. There is simply too much at stake for South Dakota's families and businesses, who have either seen their premiums rise sharply year after year, or who still have no access to an affordable plan.

Done right, health care reform will both ensure that more people have access to quality health care, and, just as critically, make the common-sense reforms that are necessary to fix an unsustainable system that threatens our fiscal future. These twin goals of addressing access, quality and costs on the one hand, and solidifying our fiscal future on the other are not mutually exclusive. In fact, they are complementary.

Unfortunately, the House bill misses this critical opportunity. While it does include many good provisions, it is not the right answer for South Dakota, it could threaten existing access to health care in our state, and it does not include nearly enough cost-containment and deficit reduction measures.

I am concerned by the projected impact of the bill's Medicaid provisions on South Dakota's state budget, and the reductions in payments for long-term care under Medicare. I have recently discussed the state's budgetary situation with Governor Rounds, along with a number of community leaders, business people and others across South Dakota, and we must take this situation very seriously. The growth in the state Medicaid program due to the recession will produce a projected 25 to 30 million dollar deficit in the state Medicaid program in 2010, and, after the expiration of the Recovery Act enhancement in the FMAP rate, a 50 to 60 million dollar deficit in FY2011.

Early analysis suggests that the House bill Medicaid provisions would impose at least $87.6 million more in new Medicaid costs on the state than the Senate Finance Committee bill. Given that budgetary impact, we have to consider the likelihood that dramatic service cuts would be the end result in South Dakota if the House bill were implemented, and that is a source of serious concern for me. It should be for every South Dakotan.

I have discussed the long-term care provisions of the House bill with a number of long-term care providers in South Dakota and have serious concerns about how the House bill would affect the future of care in our state for our seniors. While the original House legislation again has been improved in this respect by the addition of some incentive payments under Medicaid, overall, I am concerned that the cuts under Medicare to long-term care are unsustainable, and put undue financial pressure on this essential part of the health care infrastructure of South Dakota. Nursing homes will not derive the same benefit from universal coverage that hospitals will, so this is another issue that needs to be addressed as the process continues.

Another of my top priorities is the Indian Health Care Improvement Act reauthorization that has been incorporated into the broader bill. Together with the nine sovereign Native Tribes I represent, I have worked hard to advance the Indian Health Care reauthorization in the House of Representatives. I share the concerns of the Great Plains Tribal Chairman's Association (GPTCA) regarding aspects of the current version of that legislation. The GPTCA is comprised by the elected leaders of the sovereign Indian Tribes and Nations of the Great Plains, including South Dakota. I have consulted closely with the Tribes I represent. For years, the Tribes and the GPTCA have supported the Indian Health reauthorization and have been disappointed at the great length of time it has taken to bring the legislation to this point in the House. The GPTCA has reviewed the current version of the Indian Health reauthorization contained in the broader health reform bill and has serious concerns about certain provisions in the bill, principally the fact that urban Indian non-profit organizations are, in various sections outside of Title V of the reauthorization, treated on a par with federally-recognized tribes.

The federal government has a unique relationship with the 562 federally-recognized American Indian and Alaska Native tribes. This government-to-government relationship is established by our founders in the U.S. Constitution, recognized through, hundreds of treaties, and reaffirmed through executive orders, judicial decisions, and congressional action. Fundamentally, this relationship establishes the responsibilities to be carried out by one sovereign to the other. That is why these requests by nine sovereign Sioux tribes located in South Dakota are essential. I will continue to provide my full support to GPTCA's requests to improve the reauthorization in conference with the Senate, and to properly fund Indian health services.

Turning again to the broader House health care reform bill, underlying my concerns relating to Medicaid and long-term care and other issues is a fundamental concern about the effect of broader House health care reform bill

on the nation's long-term deficit, and more specifically, my view that it doesn't do enough to start bringing down the deficit and health care costs in the long term. As President Obama noted earlier this year: ''If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close.'' He's right. Skyrocketing long-term costs will bankrupt the Medicare trust fund by 2017—and that's just part of the problem we need to fix.

But when it comes to the net change in the federal budgetary commitment to health care, the House bill is seven times greater in budgetary commitment of dollars than the Senate Finance Committee bill, while falling far short of the long-term cost containment in the Senate bill. In my view, any bill with such a significant increase should have a similar commitment to cost containment. Otherwise, we'll find ourselves in the same situation we find ourselves in with Medicare—an essential program for South Dakotans that is going broke because we can't make the tough choices now and are putting those choices off until we face an immediate crisis. That's not reform—that's a recipe for fiscal disaster.

Now, the House bill does include a number of good provisions on which the vast majority of South Dakotans I have talked to agree. For instance, I strongly support provisions in this bill to require insurance companies to cover people with preexisting conditions, and to end the insurance companies' ability to cancel coverage when someone becomes sick. These practices must end. I was surprised and dismayed to see that the House Republican proposal that we also will vote on refuses to end the unconscionable practice of denying coverage for preexisting conditions. The Congress will ultimately agree on a bill that ends this practice. In addition, I support establishing health insurance exchanges to provide a transparent and competitive marketplace for individuals and businesses to buy more affordable health care plans.

Unfortunately, in my view the House bill has not come far enough from where it started, and the bill does not yet represent the right formula for South Dakota. Nonetheless, I am very optimistic that, with the House and Senate working together with the President, we will achieve a good bill for South Dakota during this Congress, because the time has come for fundamental reform.

Again—I believe the Congress has a responsibility to pass health care reform legislation that is deficit neutral, that ensures access, fairness and affordability of coverage for South Dakotans, and that takes a responsible approach to long-term costs with a focus on achieving higher quality health care outcomes. This bill meets some of these goals but not all, and I can't support it. I remain steadfastly committed to improving this legislation and I am optimistic that through the legislative process we will achieve what South Dakotans deserve, which is a fiscally responsible and sustainable reform of the health care system that will dramatically improve coverage and quality for all.

Mr. JORDAN of Ohio. Mr. Speaker, many of my colleagues from across the aisle have called this an historic day.

I wish it was an historic day!

I wish this was the day that the majority in Congress sat up and listened to the American people . . . not just the tens of thousands that stood at the steps of our Capitol to speak out in defense of protecting their health care . . . but the millions from around the country who called our offices, wrote letters to their newspapers, spoke at town hall meetings . . . or marched on Washington.

If they did, they would hear their deep and abiding concern for what will happen to their health care if this bill passes.

What will happen to the relationship between them and their family and their doctor when the heavy hand of government gets involved in medical decisions?

What will happen to seniors, and everyone taking care of their elderly parents or in-laws, when the overpromise of ''free health care'' meets the economic reality of ''rationed care'' when the federal government runs short on money?

What happens to Medicare Advantage customers whose services will be cut?

What happens to those using Health Savings Accounts whose health freedoms will be infringed upon?

What happens to the small business owner who desperately wants to hire back some employees or expand his business to provide more economic opportunities in his community? What happens when these individuals, upon whose success our nation will rise from this recession, have to pay the hundreds of billions in new taxes to pay for the massive government expansion in this bill?

Mr. Speaker, how bad does it have to get? How bad does it have to get before this Congress starts acting in a way that will help families, create jobs, and leave a better America for our children and grandchildren?

How bad does unemployment have to get? Earlier this week, it was announced that our nation has reached an unemployment rate of 10.2 percent, which is the highest unemployment rate in almost 30 years. Yet studies suggest that the taxes, mandates, and federal expansion in this bill will cost our nation another 5.5 million jobs in the private sector.

How bad does the deficit have to get? This year's deficit of over 1 trillion dollars was the highest in history. Yet this multi-trillion-dollar expenditure to take over the nation's health care system will explode the deficit, despite the fuzzy math that we've heard from the other side of the aisle.

The debt . . . it has reached a nearly insurmountable level of 12 trillion dollars. How bad does it have to get? Even without the massive uncontrolled expenditures involved with this health care bill, the national debt is projected to surpass the size of our economy in the next few years. Since when has the answer to an exploding national debt been an explosive expansion of federal government spending in areas that have always been a part of the private sector economy?

The one positive thing I can say about this bill is the pro-life victory we won with the amendment offered by my fellow pro-life colleagues, led by Mr. STUPAK and Mr. PITTS. I was proud to support that amendment because it honored the fundamental truths that life is sacred, life should be protected, and taxpayer money should never be used to take the life of an unborn child.

But Mr. Speaker, the bottom line is this: H.R. 3962 is the wrong answer to what ails America's health care system.

It is too expensive. It raises taxes. It expands the reach of the federal government into the personal health care decisions that should be left between patients and their doctors. It is a job killer. It will cause millions of Americans to lose their coverage, while expanding coverage to millions of illegal aliens.

Despite the newly-enacted pro-life protections that I fought so hard to enact both in this bill and every relevant piece of legislation before this House, it is a bad bill.

Let me close here. We are blessed to live in the greatest country in history. Our country is great, in part, because of something called the American Dream. We're a country where people, through their own hard work, can pull themselves up and reach for their goals and dreams.

Mr. Speaker, the American Dream happens because generations of parents have worked hard and sacrificed so their children can have life a little better than they did. When their children become parents, they sacrifice for their children, and the dream lives on.

This bill is just another example in the recent years of our country of borrowing for now and sending the bill to the next generation.

If we want the American Dream to live on, we must reject this bill and return to the American principles that made our nation that shining city on a hill.

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in support of H.R. 3962, the Affordable Health Care for America Act, a bill that is undoubtedly the most important single piece of legislation being considered by this 111th Congress, and possibly by any Congress in the last decade.

I commend Chairman WAXMAN from the Energy and Commerce Committee, Chairman MILLER from the Education and Labor Committee, and Chairman RANGEL from the Ways and Means Committee, and all of their dedicated staff who have invested so much time and energy into crafting a bill that addresses the complex and vast failures of our current health care system.

This has been without a doubt the most transparent and inclusive legislative effort that I have seen in my seventeen years in Congress, and I commend Speaker PELOSI for her tenacious leadership in bringing this bill to the floor.

The Affordable Health Care for America Act is not a perfect bill. With an issue that impacts so many stakeholders, and involves so many competing interests, it is doubtful any single legislative effort could ever satisfy everyone and address all the problems.

But the fact of the matter is that we cannot afford to do nothing. Study after study has shown that under our current system things will get worse unless we act now. If we are not successful in passing this health reform bill, Americans face a 50–50 chance of losing their insurance in the next 10 years, the average family will have their already prohibitive health costs increase an average of $1,800 each year, and the rising price of medications may become unaffordable even for those with insurance.

H.R. 3962 will help end this cycle of skyrocketing health care costs and represents a milestone in our nation's history by finally framing healthcare as a universal right for all Americans. With the passage of this bill we will improve the quality and affordability of health services, prioritize prevention and the reduction of health disparities, and take the

necessary albeit difficult steps to rein in the escalating costs of health care in this country.

I will vote for H.R. 3962 for many reasons. The most important is that it will provide access to affordable health care to the millions of uninsured individuals in this country. In my 34th Congressional District of California, where the average annual household income is less than $36,000, and where forty per cent of my constituents are currently uninsured, this bill will provide access to health care for 240,000 more people.

The bill also helps families in our country who have health insurance, but are struggling with high premiums and uncovered health care costs. Last year 1,120 families in my district were forced to file health care-related bankruptcies. H.R. 3962 will protect individuals like them from catastrophic out of pocket costs through an annual allowable personal expense cap.

This bill will protect our seniors from the Medicare Part D donut hole by reducing 5 percent of the cost for brand name drugs and gradually eliminating the donut hole altogether. This will be extremely beneficial for the 4,100 seniors in my district who each year hit the Medicare Part D donut hole requiring them to pay the full cost of medications they can't afford.

H.R. 3962 will help make small businesses more competitive in providing health insurance to their employees by providing tax credits up to 50 percent of the cost of the insurance. In my district approximately 15,000 small businesses would qualify for these credits.

As chair of the Congressional Hispanic Caucus Health Task Force, I commend the Affordable Health Care for America Act for its efforts to reduce health disparities and improve minority access to culturally and linguistically competent health care. The bill expands Community Health Centers which have been a cornerstone of primary care services in communities of color, and incorporates critical health disparities language guided by the Health Equity and Accountability Act of 2009. In addition, the Manager's Amendment strengthens the focus of eliminating health disparities by codifying the Office of Minority Health and establishing Minority Health Offices across all Department of Health and Human Services agencies.

As co-chair of the Congressional Study Group on Public Health, I am particularly pleased that the Affordable Health Care for America Act finally prioritizes prevention and public health in this country. The bill ensures full coverage of evidence based preventive health services, and establishes a Public Health Investment Fund that will support core public health infrastructure, help finance the delivery of community-based prevention and wellness services, and provide grants to train the next generation of Public Health workforce professionals.

Mr. Speaker, I fully believe that the Affordable Health Care for America Act is a bill that will transform our healthcare system and will play a determining role in the collective health and fiscal viability of our region, our state, and our nation.

I urge my colleagues to join me in voting yes for this bill today, to ensure that our families and communities will have the promise of a healthier tomorrow.

Mr. VAN HOLLEN. Mr. Speaker, we are taking a historic and very important step today to lower health care costs for American families and small businesses, and fix a broken health care system.

In considering the Affordable Health Care for America Act, this has been one of the most open and transparent debates in Congress. There have been countless hours of hearings and mark-ups and more than 3,000 public health care events around the country.

The Affordable Health Care for America Act contains significant protections that will provide health care consumers greater stability, lower costs, and improved quality—while all at the same time paying down the deficit. According to independent analysis conducted by the non-partisan Congressional Budget Office, the bill reduces the deficit by $109 billion over the first 10 years. And it will continue to reduce the deficit over the second 10 years.

This legislation will help the middle class by providing stable, affordable health insurance that people can count on. It will rein in health care costs for families, businesses and the government. It will ensure that if you lose your job, you won't lose your access to health care. No one should have to worry about whether they can see a doctor when they're sick because they don't have health insurance.

I have heard from countless constituents who have been victims of discrimination by insurance companies, like the family who recently shared their experience with me about their inability to obtain health insurance coverage. The father started his own company and applied for health insurance for his family, but three out of the four family members could not be fully covered due to pre-existing conditions. It turns out that he was rejected for coverage because he had two chest colds in the last 6 years and scar tissue in his lungs. For his daughter, the insurance company would only issue a policy that precludes coverage for any injury to any part of her back at any time in the future because of a previous injury of her back. And the same company refused to cover any injury to his son's knee at any time in the future from any cause due to a previous injury. It is unconscionable that the insurance company's policies precluded everyone in his family from being fully covered.

There are a number of provisions that would help this family, my constituents, and millions of Americans. Among them, the bill would end the practice of discriminating against those with pre-existing conditions, such as diabetes, cancer, a heart condition, or previous injuries. It would prohibit insurance companies from dropping health care coverage because you became sick. The bill eliminates co-pays for preventive and wellness care, and it places annual caps on what Americans pay out-of-pocket for health care services. And there would be no yearly or lifetime cost caps on what insurance companies cover.

A critical piece of this legislation is the creation of a new Health Insurance Exchange that will allow individuals and small business to comparison shop for affordable and quality health insurance coverage. The Exchange will help reduce the growth in health care spending by encouraging competition on price, quality, and transparency among a number of private health insurance companies and a public health insurance option. The public option will add choice to the health insurance market and participation is completely voluntary. That is why Consumers Union and Consumer Reports endorsed this bill. With this health care reform bill, Americans will have the freedom to keep their doctor or select another one. The choice is theirs. It preserves and strengthens the doctor-patient relationship. That's why the doctors of America under the umbrella of the American Medical Association have endorsed this bill.

The legislation takes steps to preserve and strengthen Medicare for today's seniors and future generations of retirees. For over 40 years, Medicare has been a stable, reliable program for senior citizens and people with disabilities. It provides health care coverage to approximately 45 million Americans. This bill will ensure that seniors can see their doctor of choice or find a doctor by improving Medicare reimbursement to doctors. It lowers drug costs for seniors by closing the Medicare Part D ''doughnut hole'' and allowing the government to negotiate with pharmaceutical companies for lower drug prices. And it takes steps to reduce waste, fraud, abuse, and inefficiency in the Medicare program. For all these reasons, AARP has endorsed this bill.

Thousands of small businesses in America will benefit from this bill because it will provide them greater affordability. Small businesses will gain access to the new Health Insurance Exchange that will allow them to obtain rates normally enjoyed by larger employers, lower administrative costs, greater transparency, and greater choice of plans for their employees. They will benefit from increased competition for better prices as well as tax credits for those who choose to provide health insurance for their employees.

I am pleased that this bill contains several provisions I helped author. The first, the Assessment of Medicare Cost-Intensive Diseases and Conditions, directs the Department of Health and Human Services to conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program. Part of our effort to reform the health care system is to develop cures and treatments for those conditions and diseases that have a high cost, and this will go a long way in that endeavor.

The second, which I worked on with Representative KATHY DAHLKEMPER and others, requires health insurance plans to allow young people through age 26 to remain on their parents' insurance policy, at the parent's choice. Young adults between the ages of 19 and 29 are one of the largest segments of the American population without health insurance, comprising 29 percent of the total number of uninsured Americans.

I am also pleased that we were able to include a provision that ends the special advantages for health insurance companies. For far too long, the health insurance industry has been exempt from the antitrust laws that govern most other businesses. They have abused that benefit. I believe it is long past time to repeal this exemption. By ending this antitrust exemption, we are increasing competition and preventing unfair business practices that allow health insurers to drive up the cost of health care.

Lastly, I worked with Representatives HIMES, BEAN, and others to include in the bill a provision that would allow the creation of state health insurance compacts. This would permit states to enter into agreements to allow for the sale of health insurance across state lines. The creation of state health insurance compacts is another element of the health reform

bill that will allow consumers to shop for insurance across state lines, promote choice and competition, and ensure strong consumer protections.

On the question of whether any of the insurance plans offered in the Health Insurance Exchange could cover an abortion, I support the provisions in the Rule that created a mechanism for ensuring that no public subsidies would go to pay for abortions. The non-partisan Congressional Research Service analyzed that provision and found that it prevented taxpayer dollars from going to pay for any coverage of abortions. The amendment offered by Representative STUPAK goes much further. It would effectively prevent Americans from using their own money to purchase an insurance plan in the Health Insurance Exchange that includes coverage of abortions. That would be a dramatic break with the current practice where most insurance plans provide for such coverage for individuals who choose such plans. Because the Stupak amendment would effectively prohibit individuals from using their own money to purchase such plans in the Exchange, I oppose it.

Mr. Speaker, today we stand at a historic crossroads. We can choose the road that dead-ends in the status quo—where the health insurance industry continues to call the shots and ration our health care—or we can pass this legislation and take the path that leads to a future where every American has access to affordable, quality health care.

Now I understand why the health industry is opposed. But our job is not to protect the profits of the insurance companies. Let's not protect special interests and the status quo. Let's move America forward. Let's vote yes for America.

Ms. CORRINE BROWN of Florida. Mr. Speaker, like the majority of Americans, I am well aware of the desperate need in our country for comprehensive health care reform. In fact, the immediate need for reform became crystal clear to me when, over the August district period, I went to a hospital in Jacksonville to visit a friend. This friend, who had worked in the Duval County school system for over 25 years, had lost his job, was without health insurance, was struggling to support himself, and had no idea how he was going to be able to pay the hospital bill. For the many, many Americans who find themselves in similar situations: for the woman who cannot get insurance coverage because she is diabetic and has a pre-existing condition, to the one in nine children in America without health care, to the millions of middle class American citizens who skip necessary treatments because they cannot afford it, it is for them that the Affordable Healthcare for America Act, which will ensure that all Americans are covered and have access to affordable care, is necessary.

Unfortunately, the bill passed the House without any Republican support. Although many pieces of legislation this session have advanced in a bipartisan manner, particularly in my committees of specialization, Veterans Affairs and Transportation, health care has not been an issue of biparty agreement. In 2003, the Republican Party pushed through a horrible Medicare Prescription drug law that was voted along party lines, in which the Republicans included a ''donut hole'' provision, in which there is a wide gap in coverage that forces the co-payer to pay for much of their own prescription drug costs. Fortunately, the bill on the Floor today will begin to close this loophole. Similarly, today's bill in the House as well as the Senate health care bill, are advancing without any Republican support. Social Security was created in 1935 by Franklin D. Roosevelt as part of the New Deal, Medicare, in 1965, and Medicaid, in 1965, through Title XIX of the Social Security Act. All of these programs were created by Democrats without the votes of the majority of Republicans.

One aspect of health care reform of utmost importance to me is maintaining proper funding for Disproportionate Share Hospitals (DSH), like Shands Jacksonville (and Gainesville), who provide healthcare to uninsured and/or individuals with limited incomes. Disproportionate Share Hospitals are invaluable, as they are the one true safety net for the working poor nationwide. I fought hard to keep DSH funding in the Budget Reconciliation negotiations during the Clinton years, and have been working throughout the entire process to ensure that their funding was not stripped in the health care bill before us today.

Another extremely important issue addressed in this bill is that it prevents insurance companies from denying people coverage based on pre-existing medical conditions. Indisputably, denying a health insurance plan to someone merely because they're likely to need a particular form of medical care runs contrary to the underlying reason for providing medical insurance and medical care in the first place. So the bill before the House today opens doors to quality medical care to those who were shut out of the system for much too long, and also makes prevention a key piece of this legislation's goal, since it puts a renewed emphasis on preventive care, expands access to screenings and other treatments, and even promotes wellness in the workplace.

Indeed, for nearly a century leaders from all over the political spectrum, beginning with President Theodore Roosevelt, have called and fought for health care and health insurance reform. Finally today, the House of Representatives, the People's House, is about to deliver on the promise of making affordable, quality health care available for all Americans,

The Affordable Health Care for America Act is founded on key principles of American success: opportunity, choice, competition, and innovation. Among the many positive things this bill does, a few items that stand out is that it will provide coverage to nearly all our nation's citizens, while at the same time reducing the deficit by $32 billion over the first 10 years. It will also require the Secretary of Health and Human Services to negotiate drug prices for Medicare beneficiaries; begin to close the prescription drug ''donut hole'' immediately; create a new, voluntary insurance program to make long-term care more affordable; and repeal the anti-trust exemption for health insurance companies.

For Floridians in particular, where more than one in five residents do not have health insurance, and for my constituents in Florida's third congressional district and minority communities nationwide, the need for health care reform is obvious. For the African American community and Hispanics, groups who make up nearly half of the estimated 50 million Americans who lack insurance, this is imperative. In addition, health care costs have become outright unsustainable, and experts predict that in the near future, one-fifth of our nation's GDP will go towards health care spending.

The benefits for my district, Florida's third, are numerous. In fact, the Affordable Health Care Act will: Improve employer-based coverage for 300,000 residents; provide credits to help pay for coverage for up to 192,000 households; improve Medicare for 93,000 beneficiaries, including closing the prescription drug donut hole for 6,600 seniors; allow 20,100 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 18,400 small businesses; provide coverage for 138,000 uninsured residents; protect up to 1,400 families from bankruptcy due to unaffordable health care costs; reduce the cost of uncompensated care for hospitals and health care providers by $145 million. For too long, health care has been a privilege, not a right in America. And for years our nation's leaders have fought to bring the promise of quality, affordable health care to every American.

Today is a groundbreaking moment in this historic effort. Indeed, we are now closer than ever to guaranteeing every American access to quality, affordable health insurance and giving middle-class families and businesses relief from crushing costs, while simultaneously reducing our nation's deficit.

Ms. MCCOLLUM. Mr. Speaker, today we are making history. Today the U.S. House of Representatives is making health care in the United States of America more affordable and more accessible for millions of our citizens. This legislation may not be perfect, but it is very good. It will make our country stronger, our economy more productive, and every American family healthier.

Our goal is to achieve universal coverage so that every Minnesotan and every American has the ability to access quality, affordable health care. The Affordable Health Care for America Act (H.R. 3962) comes closer than ever before to realizing that goal by extending health insurance coverage to 96 percent of Americans.

This bill will have immediate and lasting benefits for millions of Americans. It will give families the confidence and security that comes with knowing they will be able to access quality, affordable health care when they or a family member is sick. And it places affordable health care coverage within reach for millions of American families who are asking for our help.

As I have often said, I believe that health care should be a right for all Americans. Critics of making health care a right often say we already have universal health care since people can go to the emergency room and access care if they really need it. This flawed logic is the best example of why I believe health care in America is broken and must be fixed.

Our health care system is broken when we live in the wealthiest, most powerful country in the world, but health care is a privilege available to only those with enough money to afford insurance and for those of us fortunate enough to have a job that provides health insurance.

Our health care system is broken when 60 million people in this country have no health insurance coverage or are under-insured—more than 85 percent of whom are from working families.

Our health care system is broken when families are forced to postpone or skip necessary

care because premiums have increased more than 90 percent in the last nine years for Minnesota families.

Our health care system is broken when our country spends $2.4 trillion a year for health care—almost twice as much per person as any other country—but we rank 37th in the world in health care outcomes.

Our health care system is broken when you can be denied coverage for being sick, for having a baby, or for suffering from domestic violence.

Our health care system is broken when 45,000 people die in the United States each year because they lack health insurance and cannot access needed care.

We can and must do better. Today we have an opportunity to save these lives and make affordable health care insurance a reality for every American.

My constituents and all citizens across this country need to know what is in this bill to help American families and workers. This legislation will make quality health care more affordable and more accessible for every patient. It will protect families from falling into bankruptcy due to unaffordable costs by limiting out-of-pocket costs, lifting lifetime limits on coverage, and lowering premiums.

First and foremost, if you love your doctor and like your current insurance, you are free to keep what you have. This legislation does not require you to make any changes. Yet, the ranks of the insured are shrinking more every year and the numbers of satisfied citizens are falling. Millions of Americans have too little insurance, too few choices, and no options left. For those Americans—for most Americans—this legislation is a lifeline to the security they have longed for and long-deserved.

This bill will give every American the peace of mind that insurance companies can no longer deny coverage for pre-existing conditions, or cancel your coverage when you are sick and need it the most.

It includes a competitive public insurance option to guarantee that Americans will have an affordable choice among insurance providers and keep private insurers honest.

It improves health care for patients and their families by making investments to increase the number of providers, improve access to primary care, and support a patient-centered approach that focuses on quality and emphasizes prevention.

For our seniors, this legislation will strengthen Medicare by eliminating the waste, fraud and abuse that diverts health care dollars away from care and into the pockets of crooked companies. It will immediately begin closing the ''donut hole'' in the Medicare prescription drug benefit to make prescriptions more affordable. And it will ensure the financial stability and solvency of Medicare for 45 million seniors.

For our children, it will help expand coverage and ensure that the youngest Americans receive quality coverage that includes essential benefits such as vision and oral services. And it will extend coverage for young people by allowing them to remain on their parent's insurance until their 27th birthday.

The Affordable Health Care for America Act does all these things while meeting President Obama's call for new costs to be covered. In fact, the bill goes much farther by reducing the deficit by $109 billion over the next 10 years.

This comprehensive health care legislation is ambitious by necessity. I have confidence every one of these reforms will be implemented successfully because of what my state of Minnesota has accomplished. Through a combination of smart investments and an enduring commitment to care for all of our friends and neighbors, my state proved a high-quality, low-cost health care system is possible. Minnesota is consistently ranked among the highest in the nation for quality of care and rates of insured citizens—almost 92 percent. And Minnesota attains these high standards with some of the lowest costs in the country.

Unfortunately, our state is forced to work with fewer resources than most other states because of the Medicare geographic payment disparity. Medicare's outdated and unfair reimbursement system pays Minnesota doctors and hospitals at some of the country's lowest rates, despite the fact they produce some of the country's best patient outcomes. The current system rewards the amount of services provided rather than the quality of care patients receive.

Patients, providers, health plans, hospitals, and unions have all told me that ending this disparity and reversing this flawed incentive structure is the most important issue for Minnesota in the national debate on health care reform. While Minnesota's health care system is excellent today, the broken Medicare payment system threatens to undermine it in years to come.

This health care reform legislation is our last best chance to fix this problem, achieve fairness for Minnesotans, and make evidence-based, quality care the standard wherever you live in the United States. That is why I worked to unite 40 of my House colleagues who represent 17 different states in a new Quality Care Coalition. Together with my coalition co-chairs Representatives BRUCE BRALEY, RON KIND and JAY INSLEE, we created the political will we have always needed but never had to address this problem. After more than 20 coalition meetings over the course of 6 months and a series of intensive negotiations with House Leadership, our coalition secured an agreement to end the unfair treatment of high quality, low-cost states such as Minnesota. And by securing fairness for our states, we will be helping to deliver better quality for all patients in every state.

This agreement places America on a path to reward high quality, evidence based, cost-effective health care by making fundamental improvements in the delivery system. H.R. 3962 directs the highly-regarded Institute of Medicine to develop recommendations on how to modernize the Medicare payment system so it rewards value and quality. This will transform the Medicare payment system to ensure better care for patients and reduce health care costs over the long-term, and will help secure a better future for our patients, families, and seniors.

While the legislation we vote on today would make unprecedented reforms, I will continue working to improve the bill before it returns to the House for a final vote. To be truly comprehensive, health care reform legislation must reach all Americans, including the 15 million citizens employed in the nonprofit sector. Achieving parity between small nonprofit and for-profit employers in this legislation is one item of unfinished business. I am also concerned with the burden this bill places on the medical device industry to generate revenue and potentially negative impact such a tax would have on patients, workers, and small businesses. I look forward to working with House Leadership and the conference committee to help address these issues and strengthen this legislation.

Still, H.R. 3962 remains a historic achievement. This legislation addresses the needs of Minnesota's families and families across this country. It modernizes Medicare and covers the uninsured. It invests in prevention instead of paying for disease. For these reasons and many more, the Affordable Health Care for America Act has the support of over 300 state and national organizations. These supporters include the American Nurses Association, American Medical Association, SEIU, AFL–CIO, and AARP. Organizations representing millions of Americans back this legislation because they know our health care system is broken and change cannot wait another year.

Still, there are critics of health care reform that are fighting desperately to maintain the status quo. It is disappointing to see Republicans choose health care profiteers and insurance companies over reforms that Americans need and want. My Republican colleagues have offered politics and posturing but no real solutions. They have no serious alternative to H.R. 3962 to control costs, expand access and improve quality. They have made killing health reform and killing America's chance at achieving health reform their only goal. The American people deserve better.

I would like to thank Speaker PELOSI, Majority Leader HOYER, Majority Whip CLYBURN and Caucus Chair LARSON for their extraordinary leadership to bring affordable, quality health care to all Americans. Thanks are owed to the three committee chairmen—Chairman WAXMAN, Chairman RANGEL, and Chairman MILLER—who held dozens of hearings throughout the year and crafted a historic bill. I would also like to thank Chairman DINGELL for his dedicated service in introducing health care legislation for over 50 years to bring health care coverage for all Americans.

I would especially like to thank Speaker PELOSI for her attention to the concerns of the Quality Care Coalition and all of the diverse interests of the Caucus. Vice Chairman BECERRA also has my gratitude for the vital role he played in negotiating this agreement to move health care reform toward high quality, cost-effective care.

Today is a historic step toward making health care reform a reality, but it is not the end. I urge the Senate to stay focused and committed so an equally strong bill meets H.R. 3962 in conference committee. I am committed to sending a health care bill to the President's desk that will bring meaningful reform for American families, seniors and businesses. With passage of this legislation, health care will no longer be a privilege for those who can afford it.

I urge my colleagues to support H.R. 3962 and guarantee that affordable, quality health care will be accessible for every Minnesota family.

Mr. MCCAUL. Mr. Speaker, in the 72 hours we were allowed, Republicans weeded through thousands of pages of bureaucratic provisions, mandates, programs and spending. Despite its monstrous size, this health care takeover has come down to a few clear, evident points: it raises taxes, raises premiums, increases health care costs, and dumps trillions of dollars of debt on our children and

grandchildren. Small businesses and families will bear the weight of this bill for generations.

We all agree that health care reform is urgently needed, but this bill destroys the American health care system as opposed to improving it. Instead of incentivizing the private market to offer more affordable health care coverage options, it punishes small businesses and their employees. It threatens jail time for individuals who do not purchase insurance and could soon lead to the rationing of care, depriving Americans of life-saving treatments that are not deemed ''cost-effective.'' Even doctors, the most experienced in this health care debate, oppose this proposal and have shared concerns of the many clinics and hospitals that will be forced to reduce or deny services.

The over 2,000 page spending plan imposes nearly $800 billion in new taxes on individuals, families and small businesses. It places mandates on both individuals and employers which, according to the President's Economic Advisor, will result in the loss of up to 5.5 million jobs. These mandates will also discourage the hiring of low-wage and minority workers. In the face of both a recession and a 10.2% unemployment rate, Speaker PELOSI's unprecedented tax-and-spend approach will come at the expense of American citizens.

Moreover, while the majority of Americans are happy with their health care coverage, an estimated 114 million Americans will lose their insurance under Speaker PELOSI's plan and be dumped into the government-run option. The plan also cuts more than $170 billion from Medicare Advantage plans, jeopardizing millions of seniors' existing coverage. The bill puts the government in the middle of Americans' personal health care decisions, as opposed to reform based on improving the quality and affordability of health care.

While Democrats have continually touted the benefits of a public option, they themselves voted against an amendment to require enrollment for Members of Congress. This speaks volumes to the true quality of a government plan, as what I view as adequate coverage for the American public would also be adequate for my family. Furthermore, the bill also abolishes the private health insurance market, forcing all individuals to purchase coverage through a government-controlled Exchange and eliminating choices from the health care system. While this bill takes care of Members of Congress, it eliminates the freedom of choice for the American public.

Republicans have introduced numerous bills to provide improvements in the cost and delivery of health care, but we have been denied a seat at the table. Behind closed doors, the Democrats crafted a monstrosity of a bill to take over one sixth of the economy, and then limited floor debate to four or five hours on one of the most sweeping pieces of legislation we have ever seen.

The Republican alternative provides a common-sense approach to the main problems in our health care system. It would lower premiums, decrease health care costs, reign in federal spending, and allow for more options, choice, and innovation in the health care system.

The non-partisan Congressional Budget Office has estimated that average premiums under the Republican alternative would be almost $5,000 less than under the Democratic plan in 2016. It would provide incentive grants for states to further lower premiums, and allow businesses to innovate ways to promote health and wellness and curb health care spending. The alternative would also expand high risk pools, prohibit insurance companies from denying individuals with pre-existing conditions, and ensure inter-state purchasing of health insurance. These reforms would drive down the costs of health care to make it more affordable for Americans while also protecting the choice and numerous options that citizens need.

I have spoken to many health care professionals in my District as well as held town halls with my constituents, and both have expressed not only their opposition, but their fear, of this government takeover of health care. We are not listening to Americans, and we are missing the opportunity to use insight from the experts in the field to enact meaningful reform. This bill is not what Americans have asked for.

Mr. PLATTS. Mr. Speaker, I rise today in opposition to Speaker NANCY PELOSI's health care bill (H.R. 3962). I plan to vote against this legislation for numerous substantive reasons, including my concerns about its trillion dollar plus cost to taxpayers, its mandates on individuals and employers, its deep cuts to Medicare, and the strong likelihood that H.R. 3962's provisions will cost millions of Americans their jobs. H.R. 3962 is a health care bill that fails to abide by the physician's guiding principle: ''First, do no harm.''

H.R. 3962 consists of approximately 2,000 pages and costs more than $1 trillion over ten years. If adopted, this legislation will destroy millions of jobs by raising taxes on small businesses and other employers. H.R. 3962 also imposes new taxes on certain employer-provided health benefits and on medical devices such as wheelchairs and walkers. In total, H.R. 3962 includes more than $700 billion in new taxes.

Unbelievably, in the name of health care reform, H.R. 3962 cuts Medicare benefits by more than $400 billion and raises Medicare premiums, making access to comprehensive health care more difficult for our Nation's senior citizens. Additionally, over time, H.R. 3962 will move countless Americans involuntarily from private health insurance to government-run health care.

I have long maintained that there is no ''silver bullet'' for health care reform. We should aim to build upon the current health care system in a variety of ways, making health insurance more affordable and more accessible. In other words, Congress should fix what is broken in our nation's health care system and be certain not to break what is not.

Congress should adopt insurance reforms to end the practice of denying coverage due to pre-existing conditions and ensure the portability of one's health insurance. Additionally, Congress should allow small businesses to band together to negotiate insurance coverage for their employees, just as large corporations and labor unions are already allowed to do. Congress should also allow individuals to purchase health insurance across state lines from a competitive, nation-wide market and should enact responsible medical malpractice reform to lower health care costs. I plan to join with my fellow Republicans in voting for an alternative legislative proposal that includes such reforms.

The full Senate has yet to act on a health care bill of its own. Hopefully, when it does so, the Senate will adhere to the principle of: ''First, do no harm.''

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise on behalf of the nearly 50 million Americans who don't have health insurance.

On behalf of parents who have to choose between taking their sick child to the doctor and paying the electric bill on time.

On behalf of adult children who are slowly losing their parents to Alzheimer's, and yet can't afford the quality care their parents need.

In a Nation as prosperous as ours, it is a shame and a tragedy that so many families suffer, watching their loved ones die, when timely tests or early care could have prevented it.

American families have waited too long for the freedom and security that universal healthcare can provide.

I strongly support H.R. 3962, the Affordable Health Care for America Act because this legislation tells families yes.

Yes, they can afford high quality health care.

Yes, they can get health insurance even if they have a pre-existing condition.

Yes, they can expect to be treated fairly by insurance companies, regardless of their gender or age. Yes, they can keep their health insurance, even if they get sick.

And yes, we can pass health reform that protects and strengthens our economy by encouraging development and use of health information technology, generic drugs, and advanced medical devices.

It's well past time for Congress to make sure that an unforeseen illness or accident doesn't mean economic ruin for American families. To stop the abuses of health insurance companies, who play games instead of paying for health care. To ensure that Americans have the freedom to change jobs or to become entrepreneurs, instead of being locked into a job they hate because it is the only way they can afford healthcare.

I worked to make sure this bill bars insurance companies from charging women more just because they are women.

I worked to make sure that this bill creates Collaborative Care Networks, to ensure that doctors, hospitals, and other health care providers work together to provide working families, lower income Americans, and those with chronic conditions the high quality coordinated care they need to stay healthy and out of emergency rooms.

I worked to make sure this bill includes, among the choices it offers consumers, a public option that will focus on health care, not profits.

I'm proud of my work on this bill, because it means American families and businesses will have the peace of mind that comes with knowing they can access affordable, quality care when they need it.

It means that my son Joaquin can grow up in a country that is a little fairer, a little more humane, and a little more secure than the one I grew up in.

I urge my colleagues on both sides of the aisle to vote for children and families by supporting this bill.

Mr. KANJORSKI. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act.

The House has taken an important first step today to improve the affordability and accessibility of health care. While today's health care legislation is not perfect, action to address this important issue is absolutely necessary. If we do nothing to reform health care, health care costs are expected to double over the next ten years, just as they have over the last ten years.

Insured Americans pay on average $500 per year just to administer health insurance, more than double the administrative costs paid in any other country which has a government-run health care system. The McKinsey Global Institute estimates that $91 billion a year is wasted on excessive insurance administrative costs.

Because about 60 percent of all Americans under the age of 65 receive insurance through their employers, much of this waste is burdening American companies. American companies competing in the global economy cannot afford this economic disadvantage. The bill we voted on today attempts to reduce the costs of insurance to employers and employees by providing greater competition among insurers. According to a study by the Massachusetts Institute of Technology, a family of four would save $1,260 in annual health insurance premiums once this bill is enacted.

It is estimated that 96 percent of all Americans will have access to affordable health insurance under this bill. While I believe that caring for our fellow citizens is a moral imperative, it also makes economic sense to have as many people covered by insurance as possible. Families USA estimates that every insured American family pays over $1000 per year in premiums just to cover the medical expenses of the uninsured, who obtain urgently needed health care through inefficient means such as visits to hospital emergency rooms. As we face the threat of pandemics such as the current swine flu, it is in the best interest of all of our health to make sure that sick people are treated quickly and affordably so that infectious diseases are not spread.

While there are many detailed provisions in this complex legislation, it is important to note what the bill does not do. The only effect it will have on senior citizens who rely on Medicare is it will reduce their out-of-pocket costs for prescription drugs, as noted by AARP in its recent endorsement of the bill. The bill does not use tax dollars to pay for abortions. It does not require our smallest businesses to pay for insurance coverage for their employees. It will not result in the federal government controlling the delivery of health care; in fact, the nonpartisan Congressional Budget Office (CBO) estimates that only six million Americans will choose to enroll in the government-sponsored insurance plan, the so-called ''public option.'' It does not add to the federal deficit. CBO estimates that the bill will reduce the deficit by $109 billion over the first ten years.

Finally, I want to praise the House leadership for including in this bill a provision which will help to fund the education of the next generation of doctors, some of whom I hope will be educated by our region's own medical college.

We all share the goal of keeping American citizens healthy in the most humane and efficient means possible. I believe this bill is a reasonable first step toward reaching this goal.

In closing, I appreciate the opportunity to share my thoughts about this important legislation.

Mr. TIAHRT. Mr. Speaker, I rise in strong opposition to H.R. 3962. I cannot and will not support this government takeover of our health care system that will restrict choice, ration care, increase the cost of health care, greatly increase government spending, and lead to the destruction of the world's best medical care.

Americans are fed up with Washington's out of control spending, with more and more power over their daily lives being put in the hands of nameless, unaccountable bureaucrats, and with the systematic shift of the United States Government from a government OF the people to a government FOR the people. The growing discontent began with the bloated stimulus bill that did nothing but grow a bigger Washington and create more bureaucratic jobs. It increased with the government takeover of General Motors, the cap and tax bill, the placement of power in the hands of unconfirmed and unconstitutional czars, and the grossly inflated spending bills passed for fiscal year 2010. With the Democrat attempt to takeover health care, the discontent has now come to a full boil.

This spring, summer and fall the American people have spoken loudly and clearly about what they do and do not want in health care reform. The Democrats ignored these sentiments and introduced H.R. 3200 and the two Senate bills. This led to the most lively, spirited town halls in my 15 years in Congress, followed by an unprecedented number of phone calls, emails and letters sent to my office by concerned Kansans.

The American people told us what they do and do not want: they do not want a government takeover of health care, the American people do not want higher taxes, the American people do very much want to keep their health insurance and increase their choices and access for those who do not have insurance.

What was the Democrat response to their constituents? A new, bigger bill that again ignores the input of the American people and is even worse than H.R. 3200.

The new bill is a government takeover of health care. H.R. 3962 is double the original H.R. 3200 at 1990 pages long and loaded with new mandates. The word ''shall'' appears 3,425 times—in other words—this is the government telling you to do something. The bill creates 118 new bureaucracies. The Congressional Budget Office (CBO) calculated the cost of the bill at $1.2 trillion but this does not include 28 instances of hidden costs indicated by the ominous words indicating that certain programs be appropriated ''such sums as may be necessary.'' The bill raises taxes, on individuals and job creators, including a $461 billion surtax on small businesses according to the U.S. Chamber of Congress. The Pelosi bill will result in 5.5 million job losses at a time when unemployment is already over 10 percent. And to top all of that off—this bill completely rewrites 16th of our nation's economy.

H.R. 3962 cuts benefits to seniors, does not ensure that Americans can keep their health insurance, limits choice, covers even more illegal immigrants than H.R. 3200 (2.5 million more according to CRS), and allows for taxpayer funded abortions.

If H.R. 3962 is enacted into law, even the Democrats acknowledge that health care costs will increase. As PJ O'Rourke said, ''If you think health care is expensive now, wait until you see what it costs when it's free.''

My biggest concern with the Democrat proposals is the intended rationing of health care. The Obama administration has already begun to set the framework for rationed care with comparative effectiveness research. This is a very dangerous road to travel down.

In addition to all the other concerns I am also opposed to the BAUCUS and PELOSI attempt to destroy Health Savings Accounts (HSAs). HSAs are what we should be promoting as a way to expand choice, give patients more control over their medical spending, and reduce health care costs.

I want health care reform and am saddened that this process has become so political that we won't see the much needed modernization that will ensure Americans have access to the best health care for decades to come. I am saddened that states like my home state of Kansas are forced to take drastic action to try to protect their citizens from being affected by Washington's takeover of health care.

Republicans have offered better solutions and principles that should be included in any health care reform. Those principles should: let Americans who like their health coverage keep it, give all Americans the freedom to choose the health plan that best meets their needs; ensure that medical decisions are made by patients and their doctors, not government bureaucrats; and improve Americans' lives through effective prevention, wellness, and disease management programs, while developing new treatments and cures for life-threatening diseases.

The Republican 219 page bill is a plan that will lower cost and improve health care access. This bill includes: tax incentives; Association Healthcare Options to let Americans group together for greater purchasing power; limitations on defensive medicine and implementing comprehensive medical liability reform; tackling waste, fraud and abuse (a $10 Billion annual cost to taxpayers generated from Medicare alone); and incentives for savings and increased use of personal Health Savings Accounts (HSAs). In addition, the Republican plan will ensure that Americans are not prevented from health coverage due to pre-existing conditions and are not subject to lifetime caps on treatment. Unlike the PELOSI and Obama plans, the Republican plan protects Medicare for seniors. Finally, the Republican plan protects taxpayers from funding abortions or health insurance for illegal immigrants. The Congressional Budget Office has confirmed that the Republican bill will lower premiums for the American people by up to 10 percent. Under our plan, premiums for families and small businesses would be nearly $5,000 per year lower.

I strongly encourage my colleagues to vote for the Republican substitute that will provide real solutions that will meet the needs of the American people. Our constituents have spoken loudly and clearly and it is our duty as their representatives to listen to them, not ignore them and use the sacred Speaker's gavel to impose personal political goals upon them.

Mr. FILNER. Mr. Speaker, many Members of the House of Representatives have spoken at length on the ways that the Affordable Health Care for America Act will improve health care for all of our constituents. I wanted to draw attention to another significant benefit of this legislation: the creation of new high-paying jobs in this country. Let me repeat that

for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of Americans in this country who currently have no insurance will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and technicians for their care, while reducing overall healthcare costs because they will not need much more expensive hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will be a win/win for Americans: high quality health care at an affordable price.

Third, this bill will create high quality research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reducing costly invasive procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchangeable with an innovator's product. This research will create high quality and high paying jobs and it is imperative that we keep this research and these jobs in this country. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

Mr. Speaker, I do not look at this bill as one of cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country while at the same time improving the lives of ALL Americans. This bill will improve health care, create jobs and grow our economy.

Mr. COSTELLO. Mr. Speaker, today is a historic day in the House of Representatives, and will be one of a handful of votes that can be deemed the most important of our careers. We are considering today how to improve the provision of health care in America. Spiraling costs, insurance limitations and a lack of insurance coverage continue to impact families, our economy, and ultimately our way of life. It is for this reason that after careful consideration, I will vote in favor of H.R. 3962.

As the health care debate has developed this year, I have held meetings with individuals, families, health care providers, business owners and other groups. What everyone can agree on is that our health care system is broken and needs attention. At the simplest level, we need to put an emphasis on preventive medicine. As the old saying goes, an ounce of prevention is worth a pound of cure. We treat too many people in emergency rooms instead of doctors' offices, and often when they are sickest and care is the most expensive. H.R. 3962 moves us toward preventive care in a variety of ways, but chiefly through providing health insurance to 36 million more Americans. Having insurance will allow them to see a doctor on a regular basis and detect health problems earlier.

Most importantly today, passing H.R. 3962 keeps the process of health care reform moving forward. Today is a very important step, but there is still a long way to go. As we all know, the Senate is working on its version of health care reform legislation, and that bill is likely to be very different from this one, but I am confident we can craft a final product that incorporates these goals and makes our health care system better.

Mr. Speaker, I am glad that we slowed our process down and took some additional time before bringing it the floor. This is not a perfect bill, but I think it will make a positive difference for the entire country. Over 300 organizations have endorsed it, including AARP, the American Heart Association and the American Medical Association. I urge my colleagues to vote for H.R. 3962, and keep us moving toward a healthier America.

Ms. LINDA T. SANCHEZ of California. Mr. Speaker, I strongly support H.R. 3962, the Affordable Health Care for America Act, which delivers on a promise Americans have been waiting for since the New Deal, a promise that families can get the health care they need, when they need it, without facing economic ruin.

I have previously spoken about the ways that this bill will help ensure access to affordable, high quality health care for American families. But another significant benefit of this legislation which has not received much attention is its promotion of high-paying research, high tech, and manufacturing jobs.

Contrary to the claims that this is a ''job killing bill,'' in fact, this bill will create thousands of jobs here in the United States.

First, this bill will increase demand for healthcare workers, including doctors, nurses, nurse practitioners, physician assistants, home health workers, and more. More affordable insurance means more families getting the primary and chronic care they need instead of waiting until they need an emergency room. And it means more middle class American jobs that can't be exported.

Second, this bill will continue the investments begun in the American Recovery and Reinvestment Act, also known as the stimulus bill, to expand the use of health information technology.

Health IT will help better manage the quality and cost of care patients receive by eliminating duplicative tests and ensuring that patients don't receive the wrong medicine or the wrong dose. And investment in health IT creates jobs—jobs in hardware production, software design, and computer training. When we invest in quality health care for all Americans, we are investing in jobs.

Finally, this bill will promote more of what America already does so well: medical research. By allowing more Americans access to health insurance, this bill will increase the demand for advanced medical technologies that are manufactured right here in America.

And by creating a process for the Food and Drug Administration to approve so-called ''biosimilar'' drugs, this bill will encourage competition in the cutting edge field of biologic drugs.

This new class of medicines will help cure and treat more Americans at lower costs. And the promise of protection for intellectual property and an FDA structure to approve biosimilars will result in increased investment in this industry, which already provides thousands of well-paying jobs in California and across the country.

I hope to work with the Secretary of Health and Human Services, the Commissioner of the FDA, and like-minded colleagues in Congress to ensure that these important research and manufacturing jobs stay right here in the United States.

In sum, this bill preserves and promotes the strength of the American health care system: innovation. And it fixes the shortcomings: spending too much while caring for too few.

If we fail to pass this bill, we fail American families, and we fail the American economy. As a champion of both, I strongly support this bill.

Mr. ALEXANDER. Mr. Speaker, after months of meeting with constituents and business leaders, as well as hosting town halls and roundtable discussions, I can say that American public has clearly stated their opposition to this government takeover of health care.

H.R. 3962, the Affordable Health Care for America Act, states in section one that this legislation ''builds on what works in today's health care system, while repairing what's broken.'' I agree that improvements need to be made to drive down medical costs, but placing individuals under one bureaucrat–run umbrella does not build on what works or make any repairs. The bill includes the government–run public option, cuts Medicare and Medicare Advantage programs, and raises taxes on middle class families. In addition, the bill does not protect the interests of small businesses nor does it adequately address defensive medicine. And, in the midst of states struggling with fiscal constraints, it will burden them with more unfunded mandates from the federal government.

In the President's address to Congress on Sept. 9, President Obama said, ''Nothing in our plan requires you to change what you have.'' A study by the Lewin Group shows that two out of every three people would lose their current coverage, including up to 114 million people who receive health benefits through their employer or other current coverage if a government–run plan ''competes'' with private companies. I don't see the choice in this.

Medicare cuts total $162 billion. As a result, Medicare Advantage plans will drop out of the program, limiting seniors' choices and causing many to lose their current health care coverage. Medicare Advantage has been successful in providing seniors with choice, selection and value. This is especially true for residents of rural America, where seniors have previously not had sufficient private alternatives. Currently, over 600,000 seniors are Medicare beneficiaries in Louisiana, while over 10,694 seniors in the 5th District are enrolled in the Medicare Advantage program.

The bill includes taxes on individuals who do not purchase government–forced health insurance. It also imposes new taxes on businesses who cannot afford to fund government–forced health coverage for their workers, therefore violating the bill's new employer mandate and triggering an additional 8 percent payroll tax.

The bill also prohibits the reimbursement of over–the–counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), increases the penalties for non–qualified HSA withdrawals from 10 percent to 20 percent, and places a cap on FSA contributions. Because at least 8 million individuals hold insurance policies eligible for HSAs, and millions more participate in FSAs, all these individuals would not be able to keep the coverage they have without facing tax increases.

The grand total amount of tax increases included in this legislation equals approximately $729.5 billion over ten years. Imposing these new tax increases in the middle of a recession—with unemployment numbers we haven't seen since 1983—will only harm the economy and kill jobs.

This bill intends to ensure that generic biologic companies will have to do some research and clinical trials before the FDA will approve them for use in the United States. This dramatically increases patient safety as generics come to market. Likewise, keeping research and trials in the country means more jobs at home. I hope this is included in discussions as the health care debate continues in the coming months.

The CBO has also said that this bill will increase seniors' Medicare prescription drug premiums by 20 percent over the next decade. While the cost of living continues to rise during these tough economic times, I know that many cannot afford this increase. Medicare finances are rapidly deteriorating and we should be working on real solutions that ensure the long–term financial stability of Medicare.

Choice is not option in this government takeover of our health care system. I am genuinely concerned for the well–being and options that the people of this great nation have. I do not believe H.R. 3962 best represents what the American people are asking for.

I agree that improvements need to be made to our system currently in place. However, a solution should be built upon the principle that when individuals—not the government, insurance companies, or employers—are given control and ownership, we will achieve full access to coverage and see the entire system move in a more positive, patient–centered direction. America needs economic relief in the form of tax breaks for working families and small businesses, and fiscal discipline in Washington. Instead, our federal government keeps pushing policies that will impose harmful taxes and increase our national debt, saddling Americans who are already hurting with even more financial burdens. We must work to find real solutions that will help create jobs and lower health care costs.

Everyone can agree that affordability, accessibility, portability, and quality should be the outcome of any overhaul of the health care delivery system. More specifically, it should be guaranteed that medical decisions are kept in the hands of patients and their doctors; the cost of insurance is lowered, and in turn the number of Americans who have insurance is increased. The American people deserve a plan that allows them to keep their health care coverage if they like it, and have the freedom to choose the plan that best meets their needs. As I have said before, and as I will say again, I will not support any type of health reform plan that raises taxes, rations health care, eliminates employer–sponsored health benefits for working families, or allows government bureaucrats to make decisions that should be made by families and their doctors.

Mr. VISCLOSKY. Mr. Speaker, I am proud to support the Affordable Health Care for America Act, a bill that will significantly improve our healthcare system.

For too long, our healthcare system has allowed millions of Americans to go uninsured, tolerated egregious and abusive business practices by big insurance and pharmaceutical companies, and ignored skyrocketing costs. It has diminished our nation's collective health and drained our economy. The Affordable Health Care for America Act represents a significant effort to address the iniquities of our current healthcare system.

Specifically, the Affordable Health Care for America Act strengthens the healthcare market for all Americans. For those with insurance, the measure would establish benefits to be included in all health insurance options, including preventative care, mental health services, and dental and vision services for children. Additionally, the measure would establish annual and lifetime out-of-pocket spending caps to ensure that no family faces bankruptcy due to medical expenses. And the Affordable Health Care for America Act would eliminate the decades-long exemption of health insurance companies from federal anti-trust laws, enabling the regulation of abusive business practices.

For those without insurance, the Affordable Health Care for America Act would establish a public health insurance option to compete with—not replace—private insurance plans. The public health insurance option would aim to provide more Americans with healthcare coverage and would be financed through its premiums. The measure would allow the Secretary of Health and Human Services to negotiate physician and hospital rates for the public option and would prohibit insurance companies from denying coverage based on a pre-existing condition.

Importantly, the measure would repeal the prohibition on negotiating with pharmaceutical companies and would require the Secretary of Health and Human Services to negotiate the prices of prescription medications for Medicare beneficiaries. It is my sincere hope that these negotiations will ameliorate the high out-of-pocket costs for prescription medications faced by our seniors. Additionally, the Affordable Health Care for America Act would provide savings to the Medicare programs by improving payment accuracy to Medicare Advantage.

The Affordable Health Care for America Act would reduce the costs to small businesses, America's economic engine, by establishing a Health Insurance Exchange where these businesses will benefit from large group rates and a greater choice of insurance options for their employees. Further, the measure would provide tax credits to eligible small businesses for assistance with the costs of providing health insurance to their employees.

Finally, the Affordable Health Care for America Act is not only fully paid for, but according to the non-partisan Congressional Budget Office it would reduce the deficit by $104 billion over the next ten years and would continue to reduce the deficit in the following decade.

Through these provisions and others I believe that the Affordable Health Care for America Act will accomplish my goals for healthcare reform, namely to give more security and stability to those who have health insurance, to provide affordable, quality options to those who do not have health insurance, and to lower the cost of healthcare for families, businesses, and society.

Although this bill may not be perfect, it will improve our healthcare system. It is the result of a lengthy, transparent process that has helped the bill evolve and improve at each step of the way. I will continue to closely monitor the legislation's progress.

Voting for comprehensive healthcare reform at long last was a gratifying experience. I believe that a generation from now people will ask the question, what took us so long?

Mr. REYES. Mr. Speaker, this is a momentous occasion for the American people, particularly for the hundreds of thousands of El Pasoans who have unjustly struggled without health insurance in the world's wealthiest nation. The Affordable Health Care for America Act, as passed by the House, will dramatically improve the quality of life for so many families in our community, who will finally have access to quality affordable health coverage.

I am particularly pleased this legislation incorporates a provision that I, along with Majority Leader STENY HOYER, and others worked to include that will support the development of our medical school. The measure will allocate $100 million each year through fiscal year 2015 to the Department of Health and Human Services to help develop medical schools in federally-designated health professional shortage areas for construction, equipment, curriculum and faculty development. This is an exciting opportunity for our community.

The House passage of the Affordable Health Care for America Act is one of the most significant legislative victories for the people of El Paso. Our community has one of the highest concentrations of America's uninsured population, with over 230,000 residents without health coverage, one in three people. Texas has the highest rate of children and adults without health insurance in the entire nation. The status quo is unacceptable, and we can no longer afford to pass this growing problem to future generations.

While our community is spending a greater share of property taxes to pay for individuals without health coverage, insurance companies have continued to engage in practices that protect their bottom lines. For too long, insurers have been the gatekeepers to our health care system, with the power to dictate who receives health coverage and who does not. Americans with pre-existing conditions and serious illnesses are too often denied coverage or are dropped from their existing insurance plans for developing a serious illness or reaching their cap on coverage, and are denied access to the medical care they need.

When people lack access to quality affordable preventative care, they end up in our

emergency rooms for ailments that could have been treated by a family doctor or seek treatment for conditions that should have been diagnosed earlier. When these patients fail to pay their medical bills from publically-financed hospitals such as University Medical Center, local property taxes are used to cover these expenses. Since 1998, El Paso property tax payers have spent over $400 million to pay for treatment and services for those patients who could not afford to pay their medical bills.

The Affordable Health Care for America Act will dramatically reduce the number of people without insurance in El Paso. First, it prohibits insurance companies from denying coverage due to ''pre-existing conditions.'' It requires that every American obtain health coverage, and provides ''affordability credits'' to individuals and families with incomes up to 400 percent of the federal poverty level (currently $43,430 for individuals and $88,200 for a family of four).

The legislation also requires that most employers provide coverage. It includes exemptions for small businesses with payrolls of less than $500,000 and offers generous tax credits for those small businesses that elect to provide coverage for their employees. The bill creates an ''insurance exchange,'' that will offer affordable health insurance plans for individuals without employer-provided or government-provided insurance (such as Medicaid and Medicare). This exchange will include a public option to encourage competition with private insurers to keep prices low for consumers.

This bill also brings much needed relief and peace of mind for those who do have insurance coverage, as all Americans will no longer have to worry about the possibility of financial ruin due to a serious illness. It caps annual out-of-pocket expenses at $10,000 for families and $5,000 for individuals, and prohibits insurance companies from imposing lifetime limits on an individual's coverage.

Our local community leaders have expressed their support for health insurance reform, and both the city and the county have passed unanimous resolutions in support of reform. The Affordable Health Care for America Act is endorsed by over 300 national organizations and associations, including the AARP, the American Medical Association, the American Cancer Society, the American Heart Association, and many other medical professional organizations.

The passage of this landmark legislation by the House of Representatives is an historic achievement and reflects the commitment and determined leadership of President Obama and the Democratic Congress to follow through on a key promise to help middle class families, who have endured years of rising medical costs. I commend my colleagues for their determination to pass this truly historic legislation that will lower health care costs for all Americans, and strengthen our country's financial future.

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise today to oppose language in the Republican substitute that threatens the well-being of patients in hospitals across the country.

The goal of the underlying legislation is to provide affordable, quality healthcare to every American. According to The Institute of Medicine, nearly 100,000 people die every year because of medical errors in America's hospitals. I cannot understand how reducing the accountability of our healthcare practitioners would lower that number or improve the quality of healthcare in this country.

The facts are clear. Those states that restrict damage awards and limit access to courts for patients injured by negligent doctors have seen limited or no reduction in healthcare costs. Instead, many have seen an increase in the cost of malpractice insurance. In fact, for every malpractice damage award, 3 to 7 people die due to medical errors.

While we all share a goal that doctors practice medicine with confidence and avoid needless tests, we should not limit access to justice where reckless action permanently alters the lives of patients and their families. Make no mistake, that's what the Republican substitute would do.

If we want to lower healthcare costs, let us instead cut down on medical error by encouraging adoption of best practices, standardizing safety procedures that are proven to reduce infection, and lowering malpractice premiums by creating more competition in the insurance industry. I listened to the Americans who visited Washington this week. Many spoke about a fear of monopolies and in favor of increased competition. I agree. Let's make the insurance companies comply with antitrust laws and operate on the same competitive playing field as other American businesses.

One of the great guarantees the founders provided in our Constitution was the ability to address grievances in a court of law. Our courts remain a great equalizer that allows every American the opportunity to seek justice when wronged. Limiting this guarantee goes against that spirit and leaves grieving and injured families without access to justice. I ask my colleagues to join me in opposing this substitute.

Ms. CORRINE BROWN of Florida. Mr. Speaker, tonight, I'm thinking about my grandmother, and all the grandmothers out there—back in November of 2003 when the Republicans passed their Medicare Prescription Drug bill, they put a provision in there known as the donut hole. And that's why I voted against that bill because I knew that my Grandma needed her prescriptions yet couldn't afford them because of this gap in coverage. And they made it illegal for the Secretary of HHS to negotiate the prices of drugs, even though we in Congress allow the VA and DOD to negotiate drug prices.

Yet this bill closes that prescription drug loophole. It makes it impossible for insurance companies to deny people health care because of a pre-existing condition, and it allows the Secretary of HHS to negotiate drug prices, which WILL help to bring down cost.

Secondly, one of the most family friendly provisions in this bill: families can keep their children on their health care insurance policy until age 27! This will be a great assistance to young adults studying in graduate school, or those just starting out in their career and barely making enough to get by.

To whom God has given much, much is expected. I strongly urge my colleagues to vote in favor of this bill to reform health care in our country and make sure access to health care is a right for every American, not a privilege.

Mr. ETHERIDGE. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act. This bill is essential to improving North Carolina's economy and will lower health care costs for millions of Americans. I am committed to enacting comprehensive health care reform that contains costs, protects patient choice, and assures quality, affordable care for all Americans. As the only North Carolina Member on the House Ways and Means Committee, a Member of the Budget Committee, and a supporter of fiscal responsibility, I am pleased that this legislation is fully paid for and according to the Congressional Budget Office will reduce the deficit both in the short and long term.

Working families and small businesses are facing crushing health care costs that threaten their lives and livelihoods. Health care costs will reach $2.5 trillion in 2009, more than we are expected to spend on the wars in Iraq and Afghanistan this decade. Families already have experienced health care costs doubling in the past 10 years. Without reform, health care costs will skyrocket in the next decade. Independent analysis has predicted that family premiums will be $1,000 to $9,000 lower in 2016 under this legislation compared to what they would be without reform.

H.R. 3962 will improve health care for seniors in Medicare by reducing costs and extending Medicare's solvency. This bill brings an end to the prescription drug ''donut hole'' which has unfairly burdened the pocketbooks of seniors, decreasing out-of-pocket costs by $500 immediately, cutting copayments in half in the short term, and fully closing it over the next 10 years. H.R. 3962 also provides better and more timely payments to doctors who accept Medicare and attacks waste, fraud and abuse in Medicare ensuring more money goes to benefits and improving senior health and quality of life.

Too many people have their choices limited by insurance companies and financial decisions, rather than by patients and doctors. H.R. 3962 will expand individual choice and prevent insurers from denying benefits that doctors recommend. This bill will place caps on out-of-pocket health expenses, and remove the ability of insurance companies to place annual or lifetime limits on coverage. Choice will be reinforced with one-stop comparison insurance shopping through a health insurance exchange.

During this economic downturn, H.R. 3962 will help small businesses address the crushing costs of health care. In particular, this legislation will curb skyrocketing health care costs and provides greater access to health care for small businesses. Companies that offer their employees health insurance coverage will get a tax credit for two years to help them transition to, or continue, providing health benefits to their employees—paying up to 50 percent of their costs.

Mr. Speaker, as this bill moves to the Senate and then to conference, I am hopeful that we can make sure that H.R. 3962 does not unintentionally burden small businesses who employ seasonal workers. While tax incentives in the bill are designed to help small employers cover health care expenses, there are no allowances for seasonal workers common to the agricultural industry. Workers who are only employed for a short time by an employer should be able to get health insurance, but there must be provisions to ensure that this is affordable and not burdensome to their temporary employer. As we work through the process of passing a final bill to be sent to the President, I hope leadership will work with me to resolve this issue.

H.R. 3962 is fiscally responsible and will improve the health and health care of people across my district, North Carolina, and the country. I am pleased to be able to vote in favor of this historic legislation.

Ms. FOXX. Mr. Speaker, small business owners and employees need more choices of health insurance plans, not fewer. This bill will drive out the private health insurance market and permit the government to determine if the health insurance options a small business offers are ''acceptable.''

The bill places a new tax-compliance paperwork burden on all small business owners.

This bill will kill jobs. It does nothing to lower the cost or increase choice in the marketplace for America's small business. It will harm small business owners with costly employer mandates and punitive payroll taxes.

The Joint Committee on Taxation and the NFIB agree that more than one-third of the $460.5 billion raised by this bill's surtax will come from small business income.

Small business owners have shared their concerns about H.R. 3962 with me. One small business owner in Statesville N.C. summed it up:

''If this bill is passed the way it is written, my business will be unable to afford to comply with the legislation. My business has drastically cut expenses, delayed capital investments and decreased our work force to stay competitive. If H.R. 3962 is passed by Congress it will force us to close down our business and end the paychecks for the 56 employees who depend on our company to feed their families.''

Mr. LUJÁN. Mr. Speaker, as I came to the floor tonight I was reminded of a constituent, Aunt Adrian, who we lost to cancer this last year and who couldn't afford insurance, she spent her last few months worrying about bills, rather than getter better. This story didn't have to end this way.

We reached this point today because people have had enough.

People who have been ignored and shunned, because they are sick;

People who have lost their homes and all they have because a health insurance company slammed a door on them and denied them coverage they thought they had.

People who deserve to be treated fairly and with dignity.

We are here today not to frighten and scare the American people with things that are untrue

But to act, to make a difference, to have the courage and will to put the people first.

And I now know that we do have the courage and the will to get this done, Aunt Adrian and the American people deserve no less.

Ms. RICHARDSON. Mr. Speaker, I rise today in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

I would like to thank Speaker PELOSI, House Majority Leader HOYER, Congressman DINGELL, Congressman RANGEL, and Congressman WAXMAN for their skill and leadership in bringing this historic bill to the floor. I would also like to thank my colleagues who have worked so hard to bring about a workable solution to one of the most critical challenges in the history of our nation.

President Theodore Roosevelt proposed national health insurance in 1908 because he could not stand by and watch American families go bankrupt when their children fell ill. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens. Thirty years later, Congress passed the State Children' Health Insurance Plan which expanded affordable coverage to millions of poor children.

Today, this seventh day of November in the year 2009, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won't bankrupt their families. Today, we keep faith with those who came before us and those who will come after us. Today, we will pass the Affordable Health Care for Americans Act of 2009 and change America for the better.

The health care system we have now is not working for middle and working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured. There are 54 million Americans who are uninsured who need us to reform this broken system. 1 in 5 Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, House Republicans have offered a bill that they claim solves the broken health care system, but the reality is quite different from what their rhetoric makes it out to be. The fact is the Republican substitute leaves affordable health insurance out of reach for millions of Americans. It will allow discrimination based on gender, age, and pre-existing conditions to prevail in the insurance industry. It will do nothing to protect consumers. It is not the answer.

Mr. Speaker, the Affordable Health Care for Americans Act is a better bill. It is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood. This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies. This bill provides American families with greater choice. It creates a high-quality, robust, public health insurance option for families to choose from. Finally, this bill lowers costs for American families. It eliminates co-pays and deductibles for preventive care while putting an annual cap on out-of-pocket expenses for American families.

Mr. Speaker, this bill is the answer to the problems faced by real American families today. The Republican bill is fantasy. It is not grounded in reality. Now, we need to stop playing politics and focus on actually improving people's lives. H.R. 3962 will reform the health care system so that it provides quality, affordable coverage that cannot be taken away. This bill eliminates discrimination based on gender and pre-existing condition. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

As FDR once said, the test of our progress is not whether we add more to the abundance of those who have much, it is whether we provide enough for those who have little. It is time for us to move forward. It is time for us to take this great nation in a new direction. It is time for us to look out for all Americans in their time of sickness and need. The hour is late, and the need is great. I urge my colleagues to vote ''aye'' on H.R. 3962.

Mr. SHULER. Mr. Speaker, as you know I am opposed to the bill we are considering today for many reasons that I have articulated previously. I am pleased, however, that the bill strikes the appropriate balance on the issue of follow on biologics. This bipartisan compromise language will provide lower cost options to consumers and my constituents without destroying a healthy and functioning biotech industry in this country. The Barton-Eshoo biosimilar amendment in the Energy and Commerce Committee was one of the few issues that was addressed on a truly bi-partisan basis and ought to serve as model on how things should get done in Congress.

I believe it is critical that the creation of a pathway for new products does not destroy the ability or the incentives of innovator companies to develop breakthrough technologies. We have a moral obligation to provide a safe and effective pathway of bringing competition that will benefit patients. I wish we could consider this as a stand-alone bill because it would pass with the kind of overwhelming bipartisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country and in my home state of North Carolina. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries that don't have the same safety and efficacy standards that we have in the United States. With this week's devastating news that unemployment has reached 10.2 percent it is critical that we preserve jobs in America. While the innovators have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovator's products. I don't know whether these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they should occur in this country and not somewhere across the globe. Testing and research on these interchangeable biosimilars should be required to occur in this country to ensure that it is done properly and safely.

Mr. BOOZMAN. Mr. Speaker, the Pelosi Health Care Bill is a bad bill disguised as health care reform. I have heard my constituents and the American people and they say they don't want this government takeover. They want the right to make their own health care choices. I agree that we need health care reform because the costs are too high. There

is nothing more frustrating as a medical professional then when my patients can't afford the prescriptions I write for them. The Majority plan will put Washington between me and my patients and this is unacceptable.

We all deserve access to quality and affordable health care. Unfortunately, a public option doesn't guarantee that we will accomplish this. This government takeover will increase taxes, take away health care choices Americans deserve to make and create more bureaucratic red tape. We don't want reforms that come with higher costs while the quality and access to health care suffers.

The cost is a staggering $1.2 trillion and to think that won't impact our national deficit and state budgets is unrealistic. The increased price for greatly expanding Medicaid will be an unfunded mandate to Arkansas taxpayers that at the bare minimum will cost $205 million and could be as high as $596 million. This is an unfunded mandate that we cannot force Arkansans to pay. Health reform should not end up costing hardworking Americans. Our citizens deserve better

Mr. ISSA. Mr. Speaker, today I will vote in strong opposition to H.R. 3962, the ''Affordable Health Care for America Act.''

This government takeover of health care is filled with tax increases, job killing mandates, Medicare cuts, bureaucrat additions, and entitlement expansions. This bill will lead to higher health care premiums and a growth in long-term health care costs.

Despite this bill's many faults, I support the bill's language establishing a market for biosimilars which balances the desire to provide cheaper biologics with the need to continue incentivizing investment in research and development. The bipartisan language approved by the House Energy and Commerce Committee earlier this year would create an FDA approval process that allows for the continued development of biosimilar products.

This language appropriately protects intellectual property rights by encouraging the creation of new technologies and helps protect patients from possibly dangerous, insufficiently tested biosimilars. Because biologics are more complex and susceptible to change during formulation, it is of the utmost importance that we only support a process that provides for a safe biosimilar market.

It is critical at this time of 10.2 percent nationwide unemployment that the federal government allow job creating industries, like biotechnology, to continue to invest and create jobs. It is unfortunate that the Majority wrapped up a good biosimilar bill in a bad health care bill, but I hope that we have the opportunity to support the Eshoo-Inslee-Barton biosimilar provisions in a separate legislative vote.

Mr. MCCARTHY of California. Mr. Speaker, I rise today to express my strong opposition to H.R. 3962. Specifically, I am very concerned about how the House Democratic Leadership's government takeover of health care legislation will affect the biotech industry, which has been a source of innovation and job creation in California.

Californians know very well how the burden of heavy taxes and regulations can harm small businesses and innovation, as our state economy continues to lag and continues to have an unemployment rate much higher than the national average. On top of state taxes and regulatory burdens, H.R. 3962 would only add on to the devastating burdens facing our biotech industry, through its $20 billion excise tax on medical devices and by establishing a pathway for follow-on biologics that could harm innovation and American jobs.

As one of the biotech leaders in our country, California boasts more than 2,000 biomedical companies and has created more than 271,000 jobs. The proposed excise tax, whose purpose seems to be solely to raise revenue, is a job killer and would stifle innovation. It will ultimately result in making it more difficult for millions of Americans to have access to life-saving medical devices that they need for their health and well-being.

Further, H.R. 3962 would establish a new pathway for follow-on biologics that could slow advances to new life-saving therapies, and ultimately reduce the number of American jobs. The bill does not expressly require clinical trials for follow-on biologics to be completed in the United States, which could allow for these studies to be conducted overseas. Over the past decades, many innovator biologics have demonstrated to be safe, reliable and life-changing—the product of strong clinical trials and research done by dedicated researchers here in America. As unemployment has now crossed 10 percent nationally, and is over 12 percent in California, I hope that we could continue to foster the creation of jobs and research in America.

These are some of the many concerns I have with H.R. 3962, which is why I instead support the Republican health care alternative. The alternative excludes the unnecessary and burdensome excise tax in H.R. 3962, and also includes a responsible pathway for follow-on biologics by including provisions from the Pathways for Biosimilars Act, which I am a proud cosponsor of. By passing the Republican alternative, we can ensure that the American biotech industry can continue to lead the world in innovative therapies and that the necessary research and clinical testing in the field can continue to be done domestically so we can continue to create good-paying American jobs.

Californians, and all Americans, need Washington to pass strong common-sense health care solutions. But we need solutions that strike a balance in reducing health care costs, strengthening health care access, and allowing health innovators, like our biotech industry, to continue to research and improve therapies for patients. That is why I support the Republican health care alternative—it addresses the needs of patients and ensures that we keep good-paying jobs in America.

Mr. BONNER. Mr. Speaker, I rise today to state my objection—in the strongest way I know how—to Speaker PELOSI's health care bill.

This bill represents everything I have fought against during my years in public service . . . it raises taxes by hundreds of billions of dollars, it hides deficit spending with dubious accounting gimmicks, and it will vastly expand the federal government's scope and size in every aspect of our daily lives and take even greater control over one sixth of our nation's economy.

Among other things, this bill piles crushing mandates on small businesses, it wrings hundreds of billions of Medicare dollars out of our doctors, hospitals, and other providers. It decimates the popular Medicare Advantage program, which millions of seniors depend on. Moreover, it will be the mother of all unfunded mandates on state budgets which—like my home state of Alabama—are already stretched thin because unlike the federal government, most states actually balance their budgets.

Mr. Speaker, over the past several months I have heard from thousands of Alabamans who have called, written, and e-mailed my office. In August, my staff and I held 19 town meetings throughout Alabama's First District where more than 5,000 people came out to voice their opposition to this massive takeover of our health care system.

My friends and colleagues, the vast majority of the people I work for—and have heard from—are unambiguous—they do not want this bill.

In fact, most Alabamians—and, I believe, most Americans—want to preserve what's best about our health care while lowering costs and improving access. That's why I will not only be opposing H.R. 3962, but I am proud to support the Republican substitute. My Republican colleagues and I believe this bill would lower costs in both the short term and the long term, honoring our pledge for fiscal responsibility while broadening access to quality heath care through lower costs and more competition.

Mr. Speaker, I only have one vote but I will cast that vote against this legislation that The Wall Street Journal correctly dubbed, ''the worst bill ever,'' and I humbly urge my colleagues to do the same.

Ms. HIRONO. Mr. Speaker, the U.S. Congress has been grappling with how to provide all our citizens with access to affordable, quality health care since the time of President Harry Truman. H.R. 3962 represents a critical milestone in the effort to reform our health care system.

For those who have it, health insurance is not something you can take for granted. Every day 14,000 Americans lose their health insurance coverage. A recent U.S. Treasury Department report noted that approximately half of all Americans under the age of 65 will lose their health insurance coverage at some point over the next ten years. Thousands are denied coverage because of pre-existing conditions like asthma, pregnancy, arthritis, or diabetes. Millions more have no health insurance at all, including 54,000 people who live in Hawaii's Second Congressional District.

In his health care speech before Congress and the nation, President Obama appealed to the best part of us—to act unselfishly, and to put ourselves in the shoes of others. He asked us to imagine what it must be like for those who don't have insurance—to live in a State of helplessness should illness strike you or the ones you love.

H.R. 3962 is a bill that will provide for comprehensive health care reform that will protect consumers, hold insurance companies accountable, rein in health care costs, reduce the deficit, and cover 36 million uninsured Americans. In supporting this bill, I want to highlight three key points. First, for Hawaii the bill includes the Hirono Amendment that provides an exemption for Hawaii's Prepaid Health Care Act of 1974, which is our nation's first and only employer mandate law of its kind. Second, the bill will provide health insurance coverage for an unprecedented number of Americans while still reducing our deficit. And third, the bill strengthens and improves the Medicare program for our seniors.

First, there is a mistaken perception that everything and everyone in Hawaii is exempted under H.R. 3962. That is not so. The Hirono Amendment only exempts Hawaii's Prepaid Health Care Act (PHCA) and those who come under it (certain full-time employees and their employers). PHCA does not apply to part-time employees, seniors on Medicare, those without health insurance, government employees, or those covered by collective bargaining agreements.

Therefore, H.R. 3962 would apply to them. I know it is easier to talk in terms of the State of Hawaii being exempt from the bill, but that is wrong. The distinction between PHCA being exempt and the whole State being exempt is a critical distinction to make.

PHCA requires employers to contribute at least 50 percent of the premium cost for single health care coverage, and the employee must contribute the balance, provided the employee's share does not exceed 1.5 percent of his or her wages. Because of rising health care costs, Hawaii employers on average cover 94 percent of the premium cost because of the second part of Hawaii's law limiting employees' share. Hawaii employers may cover the full cost of the health insurance premium and many do cover 100 percent of the cost of single coverage. H.R. 3962 would require employers to cover 72.5 percent of premium costs for single health care coverage.

Hawaii consistently ranks among the highest nationally in terms of insurance coverage and lowest in regard to the number of uninsured. This is largely due to PHCA. Private and public health insurance cover an estimated 92 percent of our population of 1.3 million people. Of those with private insurance, 93 percent are covered through employment-based plans.

Lawrence Boyd, an economist at the University of Hawaii, estimates that per capita health expenditures in Hawaii are seven percent lower than the national average. Dr. Boyd believes that wider health insurance coverage and support for preventive health care lead to this outcome. The Hirono Amendment will provide maximum flexibility for Hawaii once a federal health care reform bill becomes law. Hawaii will be able to decide for itself to retain PHCA or come completely under the new federal law.

Second, H.R. 3962 will ensure that 96 percent of Americans will have health insurance coverage. The non-partisan Congressional Budget Office (CBO) estimates that the cost of enacting H.R. 3962 will be $894 billion, consistent with the $900 billion limit established by President Obama. The bill is fully paid for. About half of the cost of H.R. 3962 is paid for by targeting waste, fraud, and inefficiency in the federal Medicaid and Medicare programs. The other roughly half of the cost of the bill is paid for through a surcharge on the wealthiest Americans—those with incomes above $1 million for couples and $500,000 for singles; therefore, 99.7 percent of Americans will not be touched by this surtax.

While H.R. 3962 will be paid for, CBO also estimates that the bill reduces the deficit by over $100 billion in the first 10 years, and continues to reduce the deficit in subsequent years. Leading economists from educational institutions across our nation have concurred with CBO's findings and support the idea that health care reform promotes our country's economic health.

Finally, I want to address the importance of health care reform to seniors. Some of the most damaging misinformation that has circulated over the past several months on health care reform is the use of scare tactics targeted at seniors. The cynical irony is that the misinformation targeting seniors is largely perpetuated by the same people who fought the establishment of Medicare and wanted to privatize Social Security.

The truth is that H.R. 3962 will lower prescription drug costs for people in the doughnut hole; give the Secretary of Health and Human Services the authority to negotiate lower drug prices on behalf of Medicare beneficiaries; and extend the solvency of the Medicare Trust fund by five years.

Closing the doughnut hole is an especially critical issue for Hawaii, as we have the nation's largest percentage—36 percent compared with 26 percent—of Medicare beneficiaries who fall into this gap of prescription drug coverage. In its first year, H.R. 3962 will reduce the doughnut hole by $500 per beneficiary, provide a 50 percent discount on brand-name prescription drugs, and phase out the doughnut hole by 2019.

It is remarkable that in just the past two days, over 300 groups representing Americans from all walks of life—doctors, farmers, seniors, consumers, cancer and diabetes patients—have rejected the unsustainable status quo and have endorsed H.R. 3962. In its endorsement of the bill, Consumers Union—publisher of the independent, non-partisan Consumer Reports—called the health care status quo a ''consumer crisis with its crippling costs, its unreliability, and lack of access,'' and strongly endorsed the House of Representatives health care bill because it will create ''a more secure, affordable health care system.'' Other groups endorsing the House bill include the: American Medical Association, American Nurses Association, AARP, AFL–CIO, AFSCME, Americans for Democratic Action, American Cancer Society, American Diabetes Association, Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, National Association of Community Health Centers, National Education Association, Campaign for Tobacco-Free Kids, and from my district, Lana'i Community Health Center.

Now is the time to end insurance discrimination based on pre-existing conditions or gender. Now is the time to begin to close the Medicare doughnut hole for America's seniors. Now is the time to bring change to a broken system.

I urge my colleagues to vote in support of H.R. 3962.

Aloha and mahalo.

Mr. THORNBERRY. Mr Speaker, most of us agree that improvements are needed in our health care system, especially in the way we pay for health care. Health insurance costs have been increasing faster than many people can pay, and too many of us do not have health insurance.

At the same time, many aspects of our health care system are the best in the world. We need to work step-by-step to make needed improvements while we protect those parts that are improving the quality and length of our lives.

The bill before us, H.R. 3962, takes a very different course. It cuts over $400 billion from Medicare and Medicaid, increases various taxes, and fines individuals and businesses that do not sign up for the government-approved insurance, all to pay for massive new programs, including a government-run health insurance plan.

I believe that this bill will not only fail to stem the growing cost of health insurance; it will make health insurance significantly more expensive for the 85 percent of Americans who are currently insured. And it will severely affect those on Medicare and Medicaid. It will also present the largest, most intrusive growth of government into our lives in many years.

The alternative bill is a better approach. It focuses on lowering health insurance costs, and CBO agrees that it will do so by up to 10 percent. At the same time, it makes it easier for those with pre-existing conditions to obtain coverage. CBO judges that the alternative would reduce the federal deficit by $68 billion over the next ten years.

Unfortunately, other ideas have never been allowed to be considered. This bill has been railroaded through this House from the beginning. That is not the way to deal with an issue as important as health care. H.R. 3962 must be stopped so common sense health insurance reform can begin.

Mr. TIAHRT. Mr. Speaker, I rise today to express my opposition to both the rule and to the massive government takeover of health care that is before us today. There are a large number of issues that I could raise, but right now I would like to focus on one of the most blatant examples of disregard for the will of the American people found within this bill. The bill includes abortions paid for by federal dollars.

For more than 30 years, the United States federal government has not been in the business of providing funding for abortion. Since 1976 the Hyde amendment has struck a delicate, but respectful balance between those who support abortion and those who do not. While it does not make abortion illegal, it protects those who oppose abortion from being forced to support it with their taxpayer dollars. This is a fair compromise that should be included in the H.R. 3962.

Public opinion is clear on this issue. A number of polls have been conducted in the last couple of months confirming that Americans do not support federal funding of abortion. A Rasmussen Reports poll from September found that only 13 percent of Americans support abortion coverage by government-backed health insurance. A Public Option Strategies poll from September found that only 8 percent of Americans would be more likely to support a health care bill if it included federal funding for abortions. A whopping two-thirds of Americans oppose using federal dollars to pay for abortions, according to the September International Communications Research poll. This is like every other aspect of this health care bill—the American people do not want it, but Democrat leadership is attempting to ram it down our throats anyway.

This is why I support the Stupak-Pitts amendment. Their amendment would extend the same restrictions found in the Hyde amendment to cover this bill as well. It does not outlaw or prohibit abortion, or restrict those who wish to have an abortion from seeking one. But it does prevent federal dollars from being used to pay for those abortions.

I am pleased that we will be allowed to debate the Stupak-Pitts amendment, even without assurance that should it pass, the House would retain the language in conference, and

I hope that my colleagues vote in favor of the amendment. The Republican bill clearly states that abortions will not be paid for with taxpayer dollars. I urge my colleagues to vote for the Republican bill and against H.R. 3962.

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Affordable Health Care for All Americans Act. In my 21 year career, this is by far one of the most important votes I will take. I have spent the past ten months meeting with the people of Bronx, Rockland and Westchester Counties and have had heartbreaking stories shared with me about the inadequacies of healthcare.

On this historic day, our Congress honors our country, honors our citizens, and honors our moral imperative to provide all Americans with comprehensive, affordable access to quality health care.

This is the reason so many of us get up day after day after day. It is the reason why so many of us sought public office, and it is the reason why our constituents sent us to Congress—to right the wrongs of our broken healthcare system and steer our country back in the right direction.

Never again will families worry late into the night over whether their pre-existing medical conditions will prevent their loved ones from getting access to health care coverage they so desperately need.

Never again will insurance companies be allowed to drop coverage for those who have paid their premiums diligently, only to lose it when they get sick and need it most.

Never again will families have to worry that if they lose their jobs, they will also lose their healthcare coverage.

The underlying bill provides comprehensive reform to our nation's healthcare system and puts our nation back on the road to fiscal responsibility by reducing the deficit by $30 billion in the first 10 years.

Regardless of who you are, or where you live, this bill provides significant benefits to all citizens.

If you have health insurance, you can keep your doctor and your health plan. You like it, you keep it. It's that simple.

But for those that don't have health insurance, we will change that today. Of the 46 million Americans that are uninsured, 85 percent of them are in working families. Millions of Americans desperately want to purchase health insurance and can't. They've been priced out of the system. They have been priced out of a basic desire to keep them and their families healthy. 53 percent of Americans postpone care or medication because of cost. 60 percent of bankruptcies were related to medical debt. It's unfair, unsustainable and un-American to allow this failed health care system to continue.

Insurance companies have a chokehold on the market and we are breaking through that today. If you don't have health insurance, or lose your health insurance, the new health insurance exchange will provide a one stop comparison shopping market place for you of private insurance options or a new public health insurance option.

While in my heart of hearts I believe a single payer system would be the best reform of our nation's health care, I have worked tirelessly over the last year to enact a strong public option. The public option included in the bill will undoubtedly inject competition into the market for better prices and coverage of quality health insurance.

No longer will women be considered second class citizens when it comes to healthcare coverage. H.R. 3962 supports women's health care by ending the designation of pregnancy, domestic violence and caesarean sections as pre-existing conditions, and eliminating out-of-pocket expenses for preventive services including mammograms, well baby and well-child care visits. It also prohibits plans from charging women more for health coverage than men, and guarantees coverage for maternity care.

H.R. 3962 invests in Medicare. Our seniors will see improved benefits, free preventive care, better primary care and lower drug costs. The donut hole, in which seniors pay monthly premiums for drug coverage without a drug benefit, will finally be closed. I have been fighting for this since the day we enacted the Medicare Prescription drug benefit.

Young adults will have more access to affordable healthcare than ever before. Our bill allows adults to stay on their parents' healthcare plans until their 27th birthday. This measure alone will cover one out of three uninsured young adults.

Additionally, small business owners will be granted access to affordable large group rates in the new insurance exchange and tax credits to help businesses insure employees across the 17th district and our nation. I met with the Rockland Small Business Association this summer and fought to make health insurance reform workable for small businesses. 98.8 percent of small business owners will pay no surcharge and 86 percent of America's businesses are exempt from the shared responsibility requirement to provide insurance. In fact, businesses with payrolls of $500,000 or below are completely exempt from provisions in H.R. 3962.

Throughout this year, and in my role as the Senior New Yorker on the Energy & Commerce health subcommittee, I have worked hand and hand with Chairmen WAXMAN, RANGEL, MILLER, Majority Leader HOYER and Speaker PELOSI to improve the underlying bill for New York State and people nationwide.

Here are just a few of the provisions I was successful in inserting in the underlying bill.

I am proud to have reformed the Medicaid program to serve people with HIV. Under current Medicaid rules, low-income people with HIV must wait until they are disabled by AIDS before they can get covered by Medicaid. In the House bill, states could cover all people with HIV infection under state disability income and resource levels until January 1, 2013, when the new health insurance exchange is operational, at an enhanced federal match.

I worked to protect the ability of eight states, including NY to preserve Adult Day Health care programs in Medicaid. These community-based long term care programs provide comprehensive health care services in day settings.

Beneficiaries are given nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine, daily basis.

Since my time in the New York State Assembly when I was the Chair of the Assembly Committee on Alcohol and Drug Abuse, I have been championing for mental health and substance abuse services. I worked to strengthen our capacity to serve people affected by these disorders through Federally Qualified Behavioral Health Centers. My provision will establish national standards of care for persons with serious mental illness and addiction disorders. Furthermore, new reporting and accountability standards for mental health care will better integrate its providers and services within the larger healthcare system.

Many people have a family member, or are friends with someone who has autism. I worked with Rep. DOYLE, the Co-Chairman of the Congressional Caucus on Autism on several provisions dear to me. We ensured that discrimination in benefits against persons with autism are prohibited by including behavioral health treatments as part of the essential benefits package in the House health reform bill.

There is currently a shortage of appropriately-trained personnel who can assess, diagnose, treat and support patients with Autism Spectrum Disorders (ASD). These professionals require the most up-to-date practices to best care for those with autism and their families. And so we included a provision for the training for professionals working with children and adults with autism.

I advocated to improve the healthcare for maternity and newborn care in the Medicaid program. H.R. 3962 will extend important child health quality improvement provisions to traditional-eligible childbearing women and newborns and other covered adults younger than age 65. As a result of my provision, the Secretary of Health & Human Services will collect data and make recommendations on improving care for these key populations.

Finally, I was tireless in my advocacy for the Disproportionate Share Hospital (DSH) program, which assists with the cost of caring for uninsured and underinsured people at hospitals. These payments ensure that hospitals are not in financial distress from serving low-income people.

We stand here as proud Americans determined and ready to transform a broken health care system into a model of care worldwide. The cost of inaction is too great. Today, we answer the call of history, and vote for health insurance reform for America. Our nation's future depends on it.

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the ''freedom'' to be uninsured. Seniors in my district do not want us to repeal government run Medicare so that they can enjoy a ''freedom'' to be uninsured, and those without insurance now do not view themselves as enjoying some ''freedom''; they want insurance.

The Republican substitute responds to the comprehensive Affordable Health Care for America act with a bill that fails to reduce cost, fails to cover uninsured Americans, and it may study—but it does not help—those with pre-existing conditions. It does, however, attack innocent victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs. And yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of medical malpractice. For those victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts the costs of medical malpractice from the doctor to the victims' own private insurance, and in some cases causes the injured victims to lose the right to sue before they even know they've been injured. I'd like to share some specific examples of the egregious provisions included in the Republican substitute.

Under the Republican substitute, a young child whose life is forever devastated by medical malpractice can lose all right to sue on his or her eighth birthday—long before he or she reaches legal age to make his or her own decision.

Under the Republican substitute, when two or more wrongdoers act together, and one of them is able to flee or put their assets out of reach, the innocent victim is left short, while the other wrongdoer is shielded from full responsibility. They call this the ''fair share rule.''

Under the Republican substitute, it is more difficult for a medical malpractice victim to get a lawyer's help to fight against the insurance companies, because the bill permits a court to reduce the fee paid to the victim's lawyer—after the case has been fought and won. This provision penalizes victims with winning cases. One would think the purpose of this provision is to save the insurance carrier money and thereby reduce malpractice premiums; however, insurance carriers are not responsible for the victim's lawyer's fee. Insurance carriers are responsible for the defendant's lawyer's fee, so permitting the court to reduce fees paid to defendant's lawyers would actually save money and reduce premiums. The substitute does not allow that. This makes no sense. Under current practice, the victim's lawyers already don't get paid if the victim loses. Now they might not get paid even if the victim wins.

Under the Republican substitute, if the victim has health insurance that helps pay for the victim's care while the victim is waiting for the wrongdoer to be held accountable, the wrongdoer can escape legal accountability for that part of the cost entirely. The wrongdoer gets to shift the cost onto the victim's own health insurance. That's the Republican approach to health insurance reform—saddling the victim's insurer with the cost of someone else's negligence, while letting the wrongdoer off the hook.

Under the Republican substitute, the only time punitive damages would ever be available is when the wrongdoer has maliciously injured the victim that is, when the wrongdoer has committed a violent felony. And even then—even in cases of the most heinous violence imaginable—the Republican substitute caps punitive damages.

The Republican substitute is empty of any meaningful health insurance reform, and it is utterly callous to malpractice victims. None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now. The substitute should be defeated.

In contrast, the majority's Affordable Health Care for America Act reduces the number of uninsured, increases accessibility of health care, controls skyrocketing costs, and addresses the denial of coverage based on preexisting conditions. This legislation will put us on a new path where health care will be affordable to all and not just a luxury for some, and I am proud to support this historic health insurance reform legislation.

Ms. NORTON. Mr. Speaker, I support the Affordable Health Care for America Act both because of the extraordinary step forward it brings the nation and my district, the District of Columbia. First, I took steps to assure that the Affordable Health Care for America Act we expect to pass tonight would treat the District equally with the 50 states (although it does not do so for the territories). Consequently, the bill will provide coverage for 14,000 uninsured D.C. residents and affordable credits to help up to 134,000 D.C. families pay for coverage; will improve employer-based coverage for 363,000 District residents; will improve Medicare for 75,000 D.C. seniors, including closing the prescription drug donut hole for 3,300 seniors, as well as providing free preventative care and wellness check-ups for all seniors; will allow 22,200 D.C. small businesses to obtain affordable health care coverage; and will save about 400 District families from bankruptcy resulting from unaffordable health costs. The bill also will reduce the cost of uncompensated care by $126 million for the District's besieged hospitals and health care providers.

I am proud of the remarkable advances made by our bill, even though it does not meet all that I pressed to achieve. The Congress, of course, is not known for perfect bills, but the extraordinary diversity of our Democratic Caucus—from right to left—has assured that this bill represents a cross-section of the American public—urban, suburban, and rural. The incredible diversity of the Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could go to the floor only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, more wary of increasing deficits than of most other issues as well as single-payer advocates, who believe that only Medicare for all can sufficiently reduce costs while providing adequate health care to the middle class and the uninsured. Thus, there can be no doubt that the Affordable Health Care for America Act is a balanced bill.

The bill's greatest achievements are that it will reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; will end discrimination by insurers who dropped or refused to renew or sell coverage because of health status; and will ensure that coverage is affordable by providing subsidies for people in employer-based health care or through the insurance exchange of private insurers as well as a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

I particularly support this bill because it will take off the burden that the District of Columbia heroically took on, beginning with the Williams administration, to offer health care to the uninsured, without any assistance from the federal government, rather than subject them, as well as the District, to costly emergency room care, the most expensive available. The District's Health Care Alliance, which provides insurance to more than 50,000 residents lacking health insurance, who do not qualify for Medicaid or Medicare, is collapsing under the weight of increasing requests from individuals without insurance. The city had to cut its Health Alliance budget this year to 46,000 individuals, although a year ago 48,000 individuals had registered and 55,000 were expected to register in the 2010 fiscal year.

At my ''Fact Check Town Hall Meeting on Health Care Reform,'' which observers said was notable for its civility and the diversity of residents attending, it was apparent that District residents strongly support the approach taken by today's bill. By September, my office had received 2,000 contacts on health care reform, almost all supporting the reform efforts underway in the House, with only nine residents expressing opposition to any reform. Also, 276 District residents had written in opposition to parts of the proposed bill, and 220 of them opposed the public plan. Most who opposed the public plan, appeared to believe that such a plan would affect their employer-based plans, which this bill ensures cannot happen.

I believe that this bill is strong and compelling enough to offer stiff resilience to those who have been unwilling to take on the special interests and who may now believe their best hope is in the other body. Tonight, this bill provides the best hope for the health care of our nation's longsuffering people.

Mr. PAULSEN. Mr. Speaker, like many of my colleagues on both sides of the aisle, I believe the status quo of our nation's health care is unacceptable. We need real reform in this country that will lower costs and keep health care decisions in the hands of patients and their doctors.

This bill would establish a new government run bureaucracy and a public-plan that will drastically expand the role of government into personal health care, at a massive cost of more than $1 trillion. And it's important to note, that like nearly every other entitlement program, the costs from this bill will only skyrocket.

The bill raises taxes on small businesses, individuals and medical devices like pacemakers and stents. Indeed, this bill would impose $729.5 billion in higher taxes. $135 billion in taxes will be levied on business. $20 billion in taxes will be levied on medical device manufacturers. Using President Obama's economic measuring stick, as many as 5.5 million jobs could be lost from the taxes in this bill.

We all heard over and over again that, ''those of you who like your health care plan can keep it.'' What is not mentioned is that every plan will need to meet government requirements for a government seal of approval. This plan cuts $500 billion in Medicare benefits to seniors, including over $170 billion in cuts to Medicare Advantage—a plan that is used by more than 19,000 seniors in my district. These seniors will no longer get the same care and coverage that they need.

Mr. Speaker, in the bill before us there is no provision in this bill to allow small businesses to pool together, no protection for those who want keep the coverage they have, and no medical liability reform.

The health care plan I support lowers health care premiums for all Americans, guarantees affordable coverage for patients with preexisting conditions, protects seniors, Medicare benefits, includes no tax increases, enacts real medical liability reform, empowers the doctor-patient relationship, and reduces the budget deficit.

I also want to point out that I offered five amendments to the healthcare bill, but none were made in order. The first amendment would have removed the onerous medical device tax from the bill and replaced it with unobligated stimulus funding. It makes no sense to me that this bill taxes innovation and our job creators and takes away funding for life saving technology.

I had another amendment that would have required a study of the harmful effects the innovation tax would have on the medical technology industry. Americans should know the implications of the negative effects on life saving technologies in this nearly 2,000 page bill.

Yet another amendment I offered would have removed the seasonal and temporary workers from the employer mandate. This amendment would have helped to lessen the heavy burden this legislation imposes on small businesses.

In addition, I offered an amendment that would have improved and expanded health savings accounts. This would have helped make health care more affordable for the millions of people covered by high deductible health plans.

Finally, I offered an amendment to clarify that nothing in this bill would have infringed on the healthcare that was promised to our nation's veterans. Unfortunately, this health care bill makes massive changes and our nation's veterans are owed the assurance that they will have adequate care.

Mr. Speaker, I would like to close by saying that I oppose this bill because it puts the government in between the decisions of a patient and their doctor. This is simply unacceptable. Patients should have the right to make their own choices regarding the medical care they need without government interference. Whether it is taking care of your children, parents or grandparents, there is no issue that is more personal to a family than health care. No special interest group, Member of Congress or federal bureaucrat should stand between a patient and their doctor.

Americans continue to lose jobs and faith in their American government each day. This bill is not only the wrong direction for our economy but also the wrong direction for America.

Mr. BISHOP of Georgia. Madam Speaker, after months of studying the various proposals, listening to feedback from my constituents on both sides of the issue in town hall meetings, informal discussions, letters, e-mails and faxes, and after prayerful reflection, I concluded that I must support the health care reform legislation. I believe it would improve the lives of my constituents by ensuring that they have access to quality, affordable health care. H.R. 3962, while not perfect, makes substantial progress in this regard.

During my town hall meetings on health insurance reform last August, I said that we have a moral obligation to ensure that all Americans receive the health care they need to live healthy and productive lives. I have long been concerned about the poor health indicators among my constituents, and this evening I cast a vote that I believe will have a significant impact on improving the lives of Southwest Georgians now and into the future.

Georgia ranks third in obesity rates for children age 10–17; sixth in the number of tuberculosis cases; seventh in number of low birthweight babies; ninth in diabetes rates for adults; tenth in the number of uninsured; eleventh in hypertension rates; eleventh in the number of new cancer cases; and fourteenth in obesity rates for adults. These numbers are unacceptable.

H.R. 3962, when signed into law, will immediately bring about reforms that will benefit the citizens of Georgia's Second Congressional District and all Americans. The bill will immediately begin to close the donut hole in the Medicare part D prescription drug coverage for seniors. It will outlaw denial of coverage for people with pre-existing conditions, limit premium discrimination based on gender and age, and prevent insurance companies from dropping coverage when people develop serious illnesses and need it the most.

In addition, the bill increases funding for community health centers and other primary care providers, doubling the number of patients seen over five years. It will extend coverage for young people to stay on their parents' insurance plans up to their 27th birthday. It will extend COBRA health insurance coverage for displaced workers. Furthermore, it will hinder price-gouging by requiring that insurance companies disclose rate increases.

By 2013, when the mandate for coverage and the Exchange are in place, additional provisions will take effect including no more copays for routine checkups and preventive care, yearly caps on individuals' out-of-pocket expenses and no lifetime caps on what insurance companies will cover.

In addition to the benefits for Southwest Georgia, the bill will reduce the federal budget deficit by $104 billion over the next decade. It will allow states to form compacts that will enable consumers to buy policies from insurers across state lines.

With regards to small businesses, the health care legislation will provide tax credits to nearly 14,000 small businesses in the Second Congressional District who offer their employees coverage and exempts 86 percent of small businesses (those with payrolls of less than $500,000) from having to provide coverage, and continues the business deduction for those who do.

Finally, the House health care bill prohibits the use of federal funds for abortions. It also requires verification of citizenship or lawful presence for undocumented immigrants to receive coverage.

I look forward to further improvements as the bill is considered by the Senate and the Conference Committee, where differences between the House and Senate bills will be resolved. But this evening's vote is a significant step towards affordable, quality health care for all.

Mr. KENNEDY. Today is truly a historic day for all Americans, and as an elected official of this great democracy, it is an extremely proud day for me. It is an occasion to celebrate and thank all those who fought to protect our nation's democratic process. It is also an occasion to recognize and remember all those Americans who have suffered waiting for this day to arrive. We have worked together to achieve this goal of quality, affordable health care for all Americans. To all these people, I express my sincere gratitude, and I rejoice with you today that a new chapter in our history has begun.

The Affordable Health Care for America Act creates basic protections for all Americans seeking access to healthcare. No longer will insurers be able to drop you from your insurance when you get sick, nor can they deny you coverage for a pre-existing condition. A public option will offer a choice for consumers and provide real competition to keep private insurers honest. Affordability credits will help individuals and small businesses to purchase health insurance. Additionally, these reforms are fully paid for and will actually lower the deficit over the next 10 years.

I am proud that the final version of this legislation includes numerous provisions I have long advocated for and worked with my colleagues to achieve. While the initial draft of the Affordable Health Care for America Act gradually closed the donut hole for Medicare prescription drug coverage over 15 years, I am pleased to have worked with the Speaker to successfully reduce the timeline in which this critical reform will take place. The donut hole will now begin to close immediately and will close completely by 2019, providing much needed assistance and relief to seniors starting next year.

Likewise, I am also pleased that the Affordable Health Care for America Act eliminates lifetime caps, provisions of many health insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. I authored a letter, signed by 23 of my colleagues, urging this lifesaving provision to become effective immediately. I am pleased that the elimination of lifetime caps on insurance has been made effective in 2010, so that none of the 25,000 individuals who reach their lifetime caps each year will die waiting for the provisions to take place.

A key aspect of this legislation that is of particular importance to me is the extension of the mental health parity protections established into law last year by my legislation, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Not only are these protections extended to all plans in the Health Insurance Exchange, but mental health and substance use benefits are a part of the essential benefits package created by this legislation. For 67 percent of adults and 80 percent of children needing mental health care that do not receive it, this victory cannot be understated. I commend my colleagues and my fellow citizens for their leadership in recognizing that the health of the mind truly cannot be separated from the health of the body. Today marks a new day and a giant leap forward towards our transition from a ''sick care'' system to one which is preventive, collaborative, and patient-centered.

Along these lines, I have also worked closely with my colleagues to ensure that mental health and substance use screening tools, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), were included in this legislation. Severe mental illnesses are estimated to cost the U.S. hundreds of billions annually in lost wages. Screening for mental health and substance use has proven to be a significant cost saver for our health care system. The Affordable Health Care for America Act establishes a program to provide grants to support these critical services.

I will continue to work with my colleagues to ensure that our health care professionals have the tools that are needed to recognize mental health and substance use in their patients. This means ensuring that mental health and substance use education be required of all health care professionals and integrated into the medical curricula, continuing medical education, and licensing examinations. It also includes addressing the drastic shortages of child and adolescent mental health professionals by providing loan forgiveness and making grants to professional schools to develop, expand, and improve training programs for professionals who serve children and adolescents. Language to this effect is included in

some of the Senate healthcare reform legislation, and I will work with my colleagues to ensure that these critical provisions are retained.

Again, I commend my colleagues, the leadership, and my fellow Americans for their steadfast effort, diligence, and tremendous stewardship towards realizing the dream of quality, affordable health care for all Americans.

Mr. SMITH of New Jersey. Mr. Speaker, like most Americans, I believe we urgently need health care reform to provide every American access to high-quality medical care.

During the long and painful illnesses of both my parents, I had to fight with their health management organization to get them the care they deserved. Their HMO put my family through months of frustration and anguish. I know I'm not alone—tens of millions of Americans have gone through this as well. It's not right, and it's time to change that. Americans need more protection, power, and say in their health care programs, and they need us to reform the system to make it more affordable for everyone.

Regrettably, H.R. 3962, the bill before the House tonight, not only falls short, but it will make most people's health care worse, and it will certainly disempower all of us. For this reason I strongly oppose the bill—H.R. 3962.

After carefully studying H.R. 3962, I am concerned that the bill is actually a step backwards—many patients will have less, not more, access to and say over their health care if H.R. 3692 is enacted. I firmly believe we can and must reform our health care system and provide better solutions for those currently uninsured or underinsured. But we must do so without jeopardizing the quality of health care for these currently insured people and families, many of whom will see their own health care access and quality seriously eroded under the bill.

H.R. 3962 will:

Limit patient access by establishing federal bureaucracies with new authority to determine what medical treatments and services will be covered at, what costs patients will pay—Americans will be so disadvantaged that this bill makes those who don't purchase ''acceptable'' coverage (as defined by the federal government) subject to criminal fines and imprisonment up to 5 years.

Cause most Americans to lose access to their current health insurance coverage and force them into a nationally uniform public plan. It will do this by subsidizing a government-run ''public plan'' that will ultimately drive private health plans out of business. Most Americans don't want to lose their current insurance, and they trust the public plan even less than they trust private insurance, which at least has to compete for customers, and permits them to choose their doctors. This would hit my constituents especially hard—according to the Urban Institute, approximately 90% of the people in my district currently have health coverage;

Slash payments to health-care providers, threatening the continued existence of many hospitals, home health and skilled nursing facilities serving New Jersey residents.

Madam Speaker, throughout my career in Congress, I have been a steadfast supporter of Medicare for our senior citizens and the disabled. I have voted several times to preserve and protect Medicare even when I stood alone in my own party rejecting a proposal to cut $270 billion from Medicare in 1995.

That is why I find it absolutely unacceptable that H.R. 3962 cuts Medicare by a whopping $500 billion. Proponents argue that some funding will be returned through other avenues. But even if that were true, Medicare will still be drastically cut by a net of $219.4 billion, in their ''best case scenario.''

The bill also guts Medicare Advantage plans, which offer additional coverage to over 11 million seniors—15,983 in my district alone—who choose Medicare Advantage plans as the coverage that best meets their needs.

I will not vote for massive cuts in Medicare. These cuts will wreak havoc on our nation's health care system and everyone it serves, particularly the seniors and disabled. We need reform legislation that respects all human life, the most vulnerable among us which includes the frail and the disabled of all ages.

Finally, this bill will hinder economic recovery and job creation during a major recession. Just yesterday the nation's unemployment rate rose above 10 percent for the first time since 1983, and if you include those who have stopped looking for jobs and those who can only find part-time work, the rate is 17.5 percent. The bill does additional harm by:

Raising taxes on individuals and small businesses by $729.5 billion;

Failing to reform our costly and unfair system of medical liability lawsuits, which inflates health care costs by billions of dollars each year, exceeding 10% of all health care expenditures;

Mandating a $34 billion expansion of state Medicaid payments—in order to cover this massive increase, financially strapped states like New Jersey will have to cut other services; and

Costing the taxpayer, according to the Congressional Budget Office (CBO), $1.3 trillion over ten years and using budget gimmicks and tax increases to cover that cost.

I must mention two other serious problems with the bill:

It does not adequately protect the freedom of conscience of health care providers opposed to abortion, and sets up mechanisms that ration care by creating government ''waiting lists'' if there are insufficient funds to pay expenses; and

It does not require patients to verify their identity, which, according to the CBO, means that millions undocumented immigrants will receive free health care, unfairly subsidized by taxpaying citizens.

It is truly unfortunate that the Democratic leadership did not work to put forth a health care reform bill that addressed these concerns. We need a proposal that advances solutions rather than creates new problems. Let me be clear, I take a back seat to no one when it comes to working to ensure that the federal government accepts its role and is doing its part in helping people and providing a health care safety net for those in desperate need of health care support. I am proud of my record, voting to defeat cuts to and expand existing federal health care programs, while working to protect patient rights and the delivery of quality medical care. These efforts include:

Medicare/Medicaid/SCHIP. I support providing our senior citizens a high level of benefits under the Medicare program. On one occasion, I voted against a $270 billion reduction in Medicare spending. One reason I cannot support the current health care legislation is because it makes over $500 billion in cuts to Medicare. To expand health insurance to more uninsured low-income children, I voted in 1997 for legislation creating the State Children's Health Insurance Program (SCHIP) and voted last year to expand the program. SCHIP and Medicaid together cover more than 30 million low-income children, as well as 16 million adults, 6 million seniors, and 10 million persons with disabilities. That is why I have been so adamant about protecting those programs.

Community Health Centers. Federally designated community health centers are another effective means to get affordable health care to underserved communities. The health centers program includes community, migrant, homeless, and public housing health centers and provides primary and preventive care to more than 18 million individuals at over 3,700 sites located in every state and U.S. territory. I have been a consistent supporter of increased funding for the community health centers program. A significant factor in the success of community health centers is that they are managed at the community level with a concern for serving their clients in their local neighborhoods.

Veterans Health Care. As former Chairman of the House Committee on Veterans' Affairs, I fought successfully (and sometimes nearly alone) to provide increased medical services and funding for veterans health care programs. I wrote several laws to boost and expand veterans health care, including the Department of Veterans Affairs Health Care Programs Enhancement Act (PL 107–135), which expanded and enhanced veterans' healthcare services and reduced out-of-pocket costs for low income veterans by 80 percent and continues to help disabled veterans obtain the tools they need to live fuller lives. I also wrote the law, the Veterans Health Programs Improvement Act of 2004 (PL 108–422), that created 5 poly-trauma centers within the VA, and an additional 17 networked sites, that specialize in treating complex multi-trauma injuries—including severe brain injury—associated with combat injuries from Iraq and Afghanistan.

Health Care Caucuses. Working with my colleagues across the aisle, I have cofounded and currently co-chair important bipartisan health care working groups, i.e. caucuses, which aim to educate Members of Congress and increase federal resources and research on treatments and cures for specific diseases, some which effect New Jersey residents disproportionately. For instance, I serve as co-chairman of the bipartisan Congressional Alzheimer's Task Force; the Coalition for Autism Research and Education; the Spina Bifida Caucus; and the Lyme Disease Caucus. Each caucus has served as an effective forum to advance legislation that helps families combating health care challenges;

Patients Rights. As far back as 2001, I cosponsored and voted for the Patient Protection Act which contained critical patient protections to help put doctors and patients back in control of their health care decisions, rather than bureaucrats at managed care companies. Unfortunately, while separate bills passed the House and the Senate, they were never signed into law.

Insurance Reform. I voted for the Health Insurance Portability and Accountability Act of

1996 (HIPPA), which provided insurability protections for individuals moving between insurance plans in the individual or group markets and reduced or eliminated preexisting medical condition exclusion periods for such individuals. I have also been a strong advocate for allowing small businesses, associations, and non-profit organizations to band together to purchase health insurance. In acquiring health insurance, small businesses do not enjoy the benefits of economies of scale of large businesses, which allows those large businesses to spread administrative costs over a large base and provide significant leverage in negotiating lower premiums. Over 50 percent of the nation's uninsured are employed in a small business or are a dependent of such a worker.

Medical Malpractice Reform. The House of Representatives has voted to pass medical liability reform legislation with my support eight times in the past 15 years. These bills—which sought to place a cap on non-economic damages, limit punitive damages, and restrict attorneys' fees—were modeled after a California law that many credited for relatively low malpractice premiums in the state.

While we have had some significant successes in these critical areas expanding—frequently after much toil—it is indisputable that more comprehensive changes are needed, including major reforms of the private health insurance market.

The goal of responsible health care reform should be to provide credible health insurance coverage for everyone, strengthening the health care safety net so that no one is left out, and incentivizing quality and innovation, as well as healthy behaviors and prevention. This means that the current private health insurance market will have to be reformed to put patients first, and to eliminate denials for preexisting conditions and lifetime caps and promoting portability between jobs and geographic areas, including across state lines. The tax code should be modernized to promote affordability and individual control, provide assistance to low-income and middle-class families. Medicare requires reform to be more efficient and responsive, with sustainable payment rates.

Of course responsible health care reform will respect basic principles of justice: it will put patients and their doctors in charge of medical decisions, not insurance companies or government bureaucrats. It will also ensure that the lives and health of all persons are respected regardless of stage of development, age or disability.

The Republican alternative amendment does these things. It focuses on lowering health care premiums for families and small businesses, increasing access to affordable, high-quality care, and promoting healthier lifestyles—without increasing taxes or adding to the crushing debt Washington has placed on our children and grandchildren and without cutting Medicare. It also establishes a real conscience protection for health care providers and it requires verification of citizenship and identity.

I oppose H.R. 3962 because in many ways it jeopardizes coverage for those who already have it, especially seniors and the disabled. At the same time it exercises far too much top-down government control, forcing everyone toward a government plan, controlling exactly what sort of care will be offered. For this reason I support the Republican alternative amendment. It moves significantly in the right direction while applying the wisdom of Hippocrates' first principle of medicine: doing no harm.

AMENDMENT OFFERED BY MR. STUPAK

Mr. STUPAK. Mr. Speaker, I have an amendment at the desk.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Part C amendment printed in House Report 111–330 offered by Mr. STUPAK:

Page 97, strike line 13 and all that follows through page 98, line 7.

Page 110, strike lines 1 through 7.

Page 114, line 21, strike ''consistent with subsection (e) of such section''.

Page 118, line 21, strike ''(including subsection (e))''.

Page 154, after line 18, insert the following new section (and conform the table of contents of division A accordingly):

SEC. 265. LIMITATION ON ABORTION FUNDING.

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

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

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

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

(A) individual premium payments required for a Exchange-participating health benefits plan towards which an affordability credit is applied; or

(B) other nonfederal funds required to receive a federal payment, including a State's or locality's contribution of Medicaid matching funds.

(c) OPTION TO OFFER SEPARATE SUPPLEMENTAL COVERAGE OR PLAN.—Notwithstanding section 303(b), nothing in this section shall restrict any nonfederal QHBP offering entity from offering separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as—

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

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

(3) any nonfederal QHBP offering entity that offers an Exchange-participating health benefits plan that includes coverage for abortions for which funding is prohibited under this section also offers an Exchange-participating health benefits plan that is identical in every respect except that it does not cover abortions for which funding is prohibited under this section.

Page 171, strike line 5 and all that follows through page 172, line 8.

Page 182, line 22, strike ''willingness or''.

Page 246, strike lines 11 through 14.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the gentleman from Michigan (Mr. STUPAK) and a Member opposed each will control 10 minutes.

The Chair recognizes the gentleman from Michigan.

Mr. STUPAK. Mr. Speaker, I ask unanimous consent that 5 of the 10 minutes granted to our side be controlled by the gentleman from Pennsylvania (Mr. PITTS).

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

There was no objection.

Mr. STUPAK. Mr. Speaker, our amendment does one very simple thing: It applies the Hyde amendment, which bars Federal funding for abortion except in the case of rape, incest, or life of the mother to the health care reform bill. The Hyde amendment has been law in Federal funding of abortion since 1977 and applies to all other federally funded health care programs, including SCHIP, Medicare, Medicaid, Indian Health Services, veterans health, military health care programs, and the Federal Employees Health Benefits Program.

More specifically, our amendment applies the Hyde amendment to the public health insurance option and private policies purchased using affordability credits. I am not writing a new Federal abortion policy. The Hyde amendment already prohibits Federal funding of abortion and the use of Federal dollars to pay for health care policies that cover abortion. This policy currently applies to the 8 million Americans, including Members of Congress, covered under the Federal Employees Health Benefits Program, and should apply in this bill.

The amendment has no impact on those individuals with private insurance who do not receive affordability credits and in no way prohibits any individual from purchasing a supplemental abortion coverage policy. Health insurance companies can still offer policies in the exchange that cover abortion; they just can't sell those policies to individuals receiving affordability credits.

I wish to thank Speaker PELOSI for her commitment to trying to reach an agreement between all sides late last night. Unfortunately, at the last minute the deal fell apart. The Speaker then took the only appropriate action remaining, which was to allow a vote on the floor.

So we are asking Members to maintain current law and vote ''no'' on public funding for abortion. Let me also reassure my colleagues, both Democrats and Republicans, I did not buck my party. I did not buck my party leadership to trade a vote for this amendment. I did it based on principle.

This bill, with the Capps language, is the most direct assault on the Hyde

language we have had since 1997. So I ask my colleagues, Democrats and Republicans alike, let us stand together on the principle of no public funding for abortion, no public funding for insurance policies that pay for abortion. Stand with us, protect our role, and let's keep current law.

I reserve the balance of my time.

Ms. DEGETTE. Mr. Speaker, I rise to claim the time in opposition to the Stupak-Pitts amendment.

The SPEAKER pro tempore. The gentlewoman from Colorado is recognized for 10 minutes.

Ms. DEGETTE. I yield myself 3 minutes, Mr. Speaker.

Mr. Speaker, to say that this amendment is a wolf in sheep's clothing would be the understatement of a lifetime. The proponents say it simply extends the Hyde amendment, just a clarification of current law. Nothing could be further from the truth.

If enacted, this amendment will be the greatest restriction of a woman's right to choose to pass in our careers.

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Here is why: The Hyde amendment states that no Federal funds shall be used for abortions. This has been contained in our annual appropriations bills for many years.

In the Energy and Commerce Committee, the pro-choice and some pro-life Democrats came together and compromised and we said no Federal funds in this bill will be used for abortions, the Capps amendment. This bill does not spend one Federal dollar on abortions.

This Stupak-Pitts amendment goes much further. It says that as part of their basic coverage, the public option cannot offer abortions to anyone, even those purchasing the policies with 100 percent private money. The amendment further says that anyone who purchases insurance in the exchange and who receives premium assistance cannot get insurance coverage for a legal medical procedure even with the portion of their premium that is their own private money.

Well, the proponents say women can just purchase supplemental insurance for abortions. This very notion is offensive to women. No one thinks that women will have an unplanned pregnancy or a planned pregnancy that goes terribly wrong. Would we expect to have people buy supplemental insurance for cancer treatment just in case maybe they might get sick? Like it or not, this is a legal medical procedure, and we should respect those who need to make this very personal decision.

Once again, the base bill contains language that preserves the Hyde amendment. Let's keep our eyes on the goal here, providing safe medical treatment for 36 million Americans. Let's not sacrifice reproductive rights today in pursuance of that noble goal.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield myself 1¼ minutes.

I rise in support of this bipartisan amendment.

Polls have repeatedly shown that the public does not support Federal funding of abortion, yet that is exactly what is in this bill. Current law actually prevents any Federal health care plan from paying for abortion. It also prevents taxpayer subsidies from flowing to benefit packages that include abortion. However, the Capps amendment included in this legislation would have the opposite effect.

Under this bill, funds will flow from premium payments and affordability credits into the U.S. Treasury account, and that account will then reimburse for abortion services. Every dollar in the public option is a Federal dollar. Let me be clear, if the government plan covers abortion, that amounts to Federal funding for abortion. It's that simple. Our amendment would maintain the principles of the Hyde amendment, something that the large majority of Americans support.

I urge my colleagues to stand with the majority of the American people, to oppose establishing a Federal Government program that will directly fund abortion on demand, to keep the government out of the business of promoting abortion as health care, and support this amendment.

I reserve the balance of my time.

Ms. DEGETTE. I yield 1 minute to the distinguished gentlelady from Connecticut (Ms. DELAURO).

Ms. DELAURO. This amendment undermines the thoughtfully crafted and balanced language in the bill that already prohibits Federal funds from being used to pay for abortion. It attempts an unprecedented overreach of women's basic rights and freedoms in this country.

Abortion is a matter of conscience on both sides of the debate, and it goes to the very heart of our belief as citizens and as legislators. This amendment takes away that same freedom of conscience from America's women. It prohibits them from access to an abortion even if they pay for it with their own money. It invades women's personal decisions, discriminates against working women, and, put simply, violates the law of the land.

Access to quality, affordable health care coverage is a question of life or death for millions of Americans. We should not be injecting this divisive and polarizing issue into our debate.

The best vote for life we could make today would be to pass the critical reforms American families have asked for and desperately need.

I urge my colleagues to oppose this amendment.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members to please heed the gavel.

Mr. STUPAK. Mr. Speaker, I yield 45 seconds to Mrs. DAHLKEMPER from Pennsylvania to speak on the bill. She has been a stalwart on this issue, and I appreciate her support on this issue.

Mrs. DAHLKEMPER. Mr. Speaker, I want to thank Congressman STUPAK.

I rise today to ask my colleagues to support the Stupak-Ellsworth-Pitts-Kaptur-Dahlkemper-Lipinski-Smith amendment which will keep in place current Federal law on abortion funding in H.R. 3962, the Affordable Health Care for America Act.

Mr. Speaker, our amendment does not change current law regarding abortion. It does not outlaw abortion. It does not prohibit women from making a choice to which they are entitled under the law. What this amendment does do is make the House's health care reform legislation consistent with all other Federal health care programs, including Medicaid, Medicare, SCHIP, and veterans care. It prohibits Federal funding for abortions consistent with legislation that has been in place since the 1970s.

Ms. DEGETTE. I am now delighted to yield 1 minute to the gentlelady from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I rise in strong opposition to this amendment.

Contrary to what its sponsors and their supporters say, the underlying bill does prohibit Federal funding for abortion. It is written clearly and plainly on page 246, line 11, ''prohibition of use of public funds for abortion coverage.'' But apparently that isn't good enough for people whose goal really is to strip women of their right to choose altogether despite purporting to just want to maintain the status quo. So instead we have this amendment which restricts a woman's right to access a legal medical procedure in this country.

It is ironic, actually, because most of the people who support the amendment claim to oppose government interference in health care, yet this amendment is government interference and a decision that should be made between a woman and her physician.

If this amendment passes, it will be the only language in the entire legislation that actually restricts coverage of a legal medical procedure. Not one other legal medical procedure is singled out in this legislation for rationing.

I urge my colleagues to vote ''no'' on this devastating amendment.

Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentleman from Indiana, Chairman MIKE PENCE.

Mr. PENCE. Mr. Speaker, I rise in support of this amendment, though it will not change my opposition to the Pelosi health care bill. I am grateful this amendment has been brought to the floor, and I wish to commend Mr. PITTS and Mr. STUPAK for their principled leadership.

Ending an innocent human life is morally wrong, but it's also morally wrong to take the taxpayer dollars of millions of Americans and use them to provide for a procedure that they find morally offensive. In the Congress of the United States, we have a responsibility to respect the moral beliefs of the majority of the American people.

I urge my colleagues to prevent Federal dollars from funding abortions. Take a stand for life, support the Stupak-Pitts amendment, and vote ''no'' on Pelosi health care.

Ms. DEGETTE. I yield 1 minute to the distinguished gentlelady from New York (Mrs. LOWEY).

Mrs. LOWEY. I rise in strong opposition to this amendment. This is a disappointing distraction from the bill before us.

Under current law, no taxpayer funds can be used to cover abortion. While I believe abortion should be legal and safe, I have worked for years with colleagues on both sides of this issue to also make this procedure rare. If we want to reduce abortions, we should provide women health coverage for reproductive care, contraceptives to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.

This amendment threatens the rights and health of women to seek a legal procedure covered by the premiums they will pay out from their own pockets. The underlying bill would uphold current law which states that no Federal funds can support abortion. Therefore, I urge my colleagues to oppose this unnecessary and reprehensible amendment.

Mr. STUPAK. Mr. Speaker, may I inquire as to how much time we have remaining?

The SPEAKER pro tempore. The gentleman from Michigan has 2¼ minutes remaining. The gentlewoman from Colorado has 4½ minutes remaining. The gentleman from Pennsylvania has 3½ minutes remaining.

Mr. STUPAK. Mr. Speaker, I continue to reserve.

Ms. DEGETTE. Mr. Speaker, I reserve.

Mr. PITTS. Mr. Speaker, at this time, I yield 30 seconds to the gentlelady from Washington, Vice Chairwoman CATHY MCMORRIS RODGERS.

Mrs. MCMORRIS RODGERS. Mr. Speaker, many have stood before me from both sides of the aisle to ensure that Federal taxpayer dollars do not fund abortion, whether it's Medicaid, whether it's the Federal Government's own health program. Today, I stand to ensure that this policy is included in the health care bill that is being rammed through this Congress.

If we are talking about health care reform for women and children, then protection for children should start at the moment their life begins. Two-thirds of women recently polled representing all parties, races, and marital statuses object to government funding of abortion.

I urge my colleagues to support this amendment.

Mr. STUPAK. Mr. Speaker, I yield 1 minute to Mr. ELLSWORTH from Indiana, who has been a champion on this issue and has worked hard to get this amendment to where we are here today.

Mr. ELLSWORTH. Thank you, Mr. STUPAK.

Mr. Speaker, I rise today to urge the passage of this vital amendment.

Since this debate started, my goal has been to ensure Federal taxpayer dollars are not used to pay for abortions and to provide Americans with pro-life options on this exchange. I have been proud to work with Mr. STUPAK and all my colleagues and the Catholic Bishops to make the goal a reality.

Getting to this point has not been very easy, but today we're on the brink of passing health care reform that honors and respects life at every stage, including the unborn. If this amendment passes today, I will support this bill.

It is time to fix what's broken in our health care system and begin to fulfill the promises we've made to Americans that we represent. That's why I urge Members on both sides of the aisle to vote for this amendment.

Ms. DEGETTE. Mr. Speaker, I am delighted to yield 1 minute to the gentlelady from California (Ms. LEE).

Ms. LEE of California. Mr. Speaker, this amendment inserts the Federal Government further directly into the medical decisions that a woman makes with her doctor.

As a person of faith who was raised in the Catholic Church, I have the deepest respect for Mr. STUPAK and Mr. PITTS. I know personally the moral dilemmas women face in making personal decisions about abortion, but I'll tell you one thing, I remember the days of back alley abortions, and this amendment takes us one step back to those dark days.

This amendment goes way beyond the Hyde amendment that denies Federal funds for abortion and attempts to dictate to women how to spend their own money. It is simply outrageous. It is outrageous.

It further places the religious views, mind you, of some into our public policy. Again, we're a democracy; we're not a theocracy. The separation of church and State requires us as legislators to never cross this line and it allows personal religious views to be personal. We should not, as Members of Congress, compromise this separation. And low-income women especially will be hurt by this amendment. Reject it.

Mr. PITTS. Mr. Speaker, at this time, I yield 30 seconds to the ranking member of the Budget Committee, the gentleman from Wisconsin, PAUL RYAN.

Mr. RYAN of Wisconsin. Mr. Speaker, this is perhaps the worst bill I have seen come to the floor in my 11 years of serving in Congress, and what would make this bill worse is if we break with the long-standing law of preventing abortions from being funded with taxpayer dollars.

For those of us who support the protection of and the sanctity of life, the only vote, the right vote, the vote to keep a clean conscience is a ''yes'' vote for the Stupak amendment.

Ms. DEGETTE. Mr. Speaker, I am now pleased to yield 1 minute to the distinguished gentleman from New York (Mr. NADLER).

Mr. NADLER of New York. Mr. Speaker, I rise in opposition to the Stupak amendment.

Despite significant efforts made by the underlying bill to level the playing field for women and to end discrimination against them in the health insurance market, this amendment adds a new discriminatory measure against women. Under this proposal, if a woman is of low or moderate income and receives tax credits to help her to afford the premiums for a health insurance plan she purchases on the exchange, she cannot choose a plan that covers abortion services. And if she chooses the public option, she cannot receive abortion coverage at all, even if she receives no help of any kind and pays for the plan entirely by herself.

The provision inserted in the underlying bill by our colleague, Representative CAPPS, extends the Hyde amendment in current law by ensuring that no Federal dollars can be used to fund abortions. That should be sufficient.

This is a bill to extend health care to all Americans. It should not be used as a political football to try to change existing laws regarding abortion coverage.

Mr. Speaker, I reiterate my opposition to this discriminatory amendment and ask my colleagues to vote ''no.''

Mr. Speaker, I rise in opposition to the Stupak amendment.

Despite significant efforts made by the underlying bill to level the playing field for women and end discrimination against them in the health insurance market, this amendment adds a new discriminatory measure against women. Under the Stupak proposal, if a woman is of low- or moderate income and receives tax credits to help her afford the premiums for a health plan she purchases through the Exchange, she cannot choose a plan that covers abortion services. And if a woman chooses the public option, she cannot receive abortion coverage—even if she receives no help of any kind and pays for the plan entirely by herself.

The Stupak amendment says to women—if you think you might have an unintended pregnancy, you should purchase separate insurance. Put another way, this amendment requires women to plan that they will encounter an unplanned pregnancy. This defies logic and is absurd.

The compromise provision inserted in the underlying bill by our colleague, Representative CAPPS, extends the Hyde Amendment in current law by ensuring that no federal dollars can be used to fund abortions. That should be sufficient.

This is a bill to extend health care to all Americans. It should not be used as a political football to change existing law regarding abortion coverage.

Mr. Speaker, I reiterate my opposition to this discriminatory amendment and ask my colleagues to vote ''no.''

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Mr. STUPAK. Mr. Speaker, I continue to reserve the balance of my time.

Ms. DEGETTE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentlewoman from Minnesota, MICHELE BACHMANN.

Mrs. BACHMANN. Mr. Speaker, it all begins with life and with protecting the most vulnerable among us, the unborn. Life is the watershed issue of our generation. How can one claim to call the destruction of innocent human life ''health care''?

Orwellian statements aside, it is the duty of government to preserve and protect human life. If we do nothing else tonight, let's choose life.

Ms. DEGETTE. I inquire of the Speaker as to the time remaining.

The SPEAKER pro tempore. The gentlewoman has 2½ minutes. The gentleman from Michigan has 1¼ minutes remaining. The gentleman from Pennsylvania has 2 minutes remaining.

Ms. DEGETTE. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Illinois (Mr. QUIGLEY).

Mr. QUIGLEY. Mr. Speaker, the health care bill we are considering today makes a strong statement that everyone in this country deserves access to health care.

For over 8 months, this body has strived to overcome the health care inequalities in our country, but this amendment disrupts that sense of equality. This amendment says that only women who can afford insurance deserve access to reproductive health care. This amendment says that women who need a little help paying for health care have to surrender their right to privacy.

This amendment will serve only to hurt low-income women, and it will restrict their ability to access reproductive health care even with their own money. It is wrong and we should oppose it.

Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentleman from Nebraska, JEFF FORTENBERRY.

Mr. FORTENBERRY. Mr. Speaker, the vast majority of Americans oppose—do not want—their government funding abortion.

I want to thank Mr. STUPAK and Mr. PITTS for this amendment to prohibit Federal funding for abortion in the guise of health care reform. Women deserve better.

Last week, we heard a lot of talk about compromise. Well, Mr. Speaker, neither a child in an early phase of life nor an elderly person clinging to each breath in the waning days of this life should ever be subject to a compromise. I hope that, if House has learned anything from this debate, it is this: that we must first do no harm. It is not ours to decide who lives or who dies.

Ms. DEGETTE. Mr. Speaker, I am now delighted to yield 30 seconds to the distinguished Chair of the Rules Committee and the co-Chair of the Congressional Pro-Choice Caucus, the gentlewoman from New York (Ms. SLAUGHTER).

Ms. SLAUGHTER. I thank the gentlewoman for yielding.

Mr. Speaker, for over 30 years, we lived in this House in peaceful co-existence with the pros and cons getting together on the fact that the Hyde amendment said that no Federal money can be spent—the strongest conscience clause in the world—which is now being strengthened, by the way, in this bill. We on our side simply have the law.

I am very concerned about this bill because, in my own case and in the cases of many of my colleagues, it means 30 or 40 years of our life is being canceled out with this amendment. After the things that we have fought for, we are driving now, I am afraid, young women and poor women who cannot afford to buy their own insurance policies out of their pockets back to the back alley. I dread to see that day.

Mr. PITTS. Mr. Speaker, we are prepared to close on our side.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Wisconsin (Ms. BALDWIN).

(Ms. BALDWIN asked and was given permission to revise and extend her remarks.)

Ms. BALDWIN. Mr. Speaker, I rise in opposition to this amendment.

A journalist asked me a few years ago if I could point to one thing that has contributed the most to the empowerment of women in our society. In answer to that query, I might have pointed to the 19th Amendment to the Constitution giving women the right to vote, or Title VII of the Civil Rights Act of 1964, or laws mandating equal pay for equal work. But instead, I responded to that journalist that it is the array of legal choices a woman now has that make it possible for her to plan her family—to decide whether to have children, and to decide when to have children. We refer to this array of choices as ''reproductive freedom.''

In the days before women were able to legally access contraception and abortion services, women often had to drop out of school, few could pursue careers in the professions, and too many women in desperate circumstances lost their lives from so-called back-alley abortions.

In 1970 women made up a third of the workforce. Today for the first time in history, women make up half of the U.S. workforce. In 1970, ten women served in the House of Representatives. Today there are 76. In 1970, the percentage of female medical students was 9.6 percent. This year, women are 48 percent of our Nation's medical students. In 1970, the percentage of women in law school was 8 percent. Today, 46.7 percent of law students are female.

These are just some of the changes in the role of women in American society that have occurred over the years during which women have secured the right to a full range of family planning options.

The Stupak/Pitts amendment is an erosion of a woman's reproductive freedom. Access to abortion services in the United States is already severely limited. State laws mandating waiting periods, the lack of insurance coverage of abortion and the scarcity of clinics providing abortion services mean that the right to a safe and legal abortion for many women is already pretty hollow. If this amendment is adopted, a woman's right to choose will be further limited.

I urge my colleagues to oppose this amendment.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentlewoman from New York (Mrs. MALONEY).

(Mrs. MALONEY asked and was given permission to revise and extend her remarks.)

Mrs. MALONEY. Mr. Speaker, I rise in strong opposition to this amendment.

Mr. Speaker, it is outrageous that even the historic bill to extend health coverage to 96 percent of Americans includes an abortion fight because of the anti-abortion movement.

The Stupak amendment is a huge step backwards for American women.

Mr. Speaker, I rise in strong opposition to the Stupak/Pitts amendment which plainly discriminates against women, puts women's health at risk, and marks an unprecedented restriction on people who pay for their own health insurance.

The commonsense Capps Compromise which was agreed to during debate in the Energy and Commerce Committee ensures that taxpayers will not be paying for abortion and reflects the status quo and current law.

It prohibits federal funds from being used for abortion but still allows women to use their own money to buy the coverage they need.

Despite this effort to address concerns raised by pro-life Members, Representatives STUPAK and PITTS decided to further restrict women's access to care by offering their shortsighted, dangerous, and discriminatory amendment to H.R. 3962.

The Stupak/Pitts amendment would make abortion coverage virtually inaccessible for most women in the new exchange.

It does so by:

(1) Banning abortion coverage in the exchange for women who receive subsidies, except by separate rider that they could only purchase with their own, private funds.

(2) Making it highly unlikely that women buying insurance in the exchange with their own money could obtain abortion coverage.

It is an outrage that at time when we are making historic changes—expanding American's access to health care—a group of legislators are bonding together to deprive women of the very health care they both need and deserve.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentlewoman from Maryland (Ms. EDWARDS).

(Ms. EDWARDS of Maryland asked and was given permission to revise and extend her remarks.)

Ms. EDWARDS of Maryland. Mr. Speaker, I rise in opposition to this amendment.

Ms. DEGETTE. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. No matter how many times it is said, our health reform bill does not allow one Federal dollar for abortions.

This Stupak-Pitts amendment goes way beyond current law. It says a

woman cannot purchase, using her own dollars, coverage that includes abortion services. Even middle class women who are using exclusively their own money will be prohibited from purchasing a plan including abortion coverage, and this is in every single public or private insurance plan in the new health care exchange. Her only option is to buy a separate insurance policy that covers an abortion, a ridiculous and unworkable approach since no woman plans an unplanned pregnancy.

This amendment is a radical departure from current law, and it will result in millions of women losing the coverage they already have. Our bill is about lowering health care costs for millions of women and their families. It is not about further marginalizing women by forcing them to pay more for their care.

This amendment is a disservice and an insult to millions of women throughout the country. I urge a ''no'' vote on this amendment.

The SPEAKER pro tempore. The Chair will remind the gentlewoman from Colorado that she has the right to close.

The gentleman from Michigan has 1¼ minutes remaining. The gentleman from Pennsylvania has 1½ minutes remaining. The gentlewoman from Colorado has 30 seconds remaining.

Mr. STUPAK. Mr. Speaker, I yield 15 seconds to the gentleman from Illinois (Mr. LIPINSKI) to state how current laws are maintained with the Stupak amendment.

Mr. LIPINSKI. Mr. Speaker, I thank my colleagues, especially Mr. STUPAK, for their perseverance as we work together on this amendment. Every year for over three decades, including this past July, we have approved the Hyde amendment.

I ask my colleagues again tonight: do the same thing, and approve the Hyde amendment in this bill.

Ms. DEGETTE. Mr. Speaker, I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield to the gentleman from Texas (Mr. GOHMERT) for a unanimous consent request.

(Mr. GOHMERT asked and was given permission to revise and extend his remarks.)

Mr. GOHMERT. Mr. Speaker, I rise in support of the wonderful work in the Stupak-Pitts amendment, addressing things like the money on page 110 for abortions.

Mr. PITTS. Mr. Speaker, I yield the balance of the time to the Chair of the Pro-Life Caucus in support of this bipartisan amendment, the gentleman from New Jersey, CHRIS SMITH.

Mr. SMITH of New Jersey. This week, another Planned Parenthood clinic director resigned after watching an ultrasound of an actual abortion in progress.

Self-described as extremely prochoice but now pro-life, Abby Johnson said she watched an unborn child ''crumple'' before her very eyes as the infant was vacuumed and dismembered by a suction device 20 to 30 times more powerful than a household vacuum cleaner.

Ms. Johnson said and told ABC News, ''I could see the baby try to move away. I just thought, 'What am I doing?' ''Never again.''

Mr. Speaker, abortion not only kills children; it harms women physically and psychologically, and it risks significant harm to subsequent children.

Recently, the Times of London reported, ''Women who have had abortions have twice the level of psychological problems and three times the level of depression as women who have given birth or never been pregnant.'' The Times said ''senior obstetrians and psychiatrists say new evidence has uncovered a clear link between abortion and mental illness. . . .''

Numerous studies show that the risk of preterm birth to children born to women who have had abortions increases. It skyrockets. One abortion preterm births goes up by 35 percent, two abortions a staggering 93 percent. One of the the leading causes of mental and motor retardation is prematurity.

We have and are going to have more disabling, because of abortion. If we truly don't want to see more abortions and if we want to reduce them, don't fund it.

The Guttmacher Institute has said, formerly the research arm of Planned Parenthood, that prohibiting Federal funds for abortion reduces abortion by 25 percent.

Millions of people are alive today because of the Hyde amendment, because funding was not there to effectuate their demise. Vote for the Stupak-Pitts amendment. It will save lives.

The SPEAKER pro tempore. The gentleman from Michigan has 1 minute remaining.

Mr. STUPAK. Mr. Speaker, to close on our side, I yield 1 minute to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. I thank the gentleman.

With respect for all of my colleagues, I rise in support of the Stupak amendment, which maintains existing Federal law, the Hyde amendment, on the compelling issue of abortion.

For 34 years, citizens of conscience have weighed in on this important moral and legal issue. Let me repeat: This amendment reaffirms longstanding, existing law and nothing more. It represents the broad consensus of the American people after 34 years of consideration on this issue. This is what it says:

''No Federal funds 'authorized under this act may be used to pay for any abortion or cover any part of the costs of any health plan that includes coverage of abortion,' except in the cases of the life of the mother, rape or incest.''

The amendment does no more, no less. It is similar to language that applies in Federal law on Medicaid, Medicare, Veterans Affairs, the CHIP program, and the Federal Health Employees Program, which is a model for how this language should be applied. It has been tried, tested and proven. The inclusion of this amendment clarifies the bill's language on the potential fungibility of premium dollars.

I urge my colleagues to support the amendment and the bill.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I rise in opposition to this amendment.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in strong opposition to this amendment.

This amendment critically threatens women throughout America, and is unquestionably a ban on abortion coverage. H.R. 3962 already provided for no federal dollars to be used for abortion—now this bill denies women the reimbursement for insurance to provide them good health care.

This amendment acutely threatens the personal liberties of our country's most vulnerable women. It negatively affects these women's health, wellbeing, and financial security. This amendment will disproportionally affect women of color. According to the Center for Disease Control, ''the abortion ratio for black women (467 per 1,000 live births) was 2.9 times the ratio for white women (158 per 1,000), and the ratio for women of the heterogeneous ''other'' race category (319 per 1,000) was 2.0 times the ratio for white women. The abortion rate for black women (28 per 1,000 women) was 3.1 times the rate for white women (nine per 1,000), whereas the abortion rate for women of other races (18 per 1,000 women) was 2.0 times the rate for white women.'' We should not be so naïve to believe that these statistics represent anything less than the reality that minority women have less financial and personal autonomy. Women who decide to abort a pregnancy are not acting on whim or caprice. Rather, the decision to abort is a painful decision process borne out of necessity. I do not support these higher statistics among minority women, however their lives should not be jeopardized because of botched abortions.

As a woman of faith myself, the issue of abortion is very dear to me. I must begin by saying that I am not pro-abortion, I am prochoice. The early termination of a fetus is a terribly sad and unfortunate event, and the decision to abort is a long and difficult one. Situations arise in which a woman is forced to make the very tough decision about something very private and personal. In situations like this I believe strongly in a woman's right to choose. It is her body and any law prohibiting woman from having total control over their bodies is in violation of our constitutional rights.

I have always supported a woman's right to choose. The decision to have a baby is something between a woman, her family, her faith

and her doctor. This is an instance where the federal government does not need to be involved. It is my hope that society will continue to be progressive in their decisions, and if a woman decides to terminate her pregnancy, there are places that she can go to have the procedure done safely.

The Supreme Court in 1973, in the landmark case of Roe v. Wade, ruled that a woman's right to have an abortion is a constitutionally protected right. Judge Blackmon wrote that "a statute that criminalizes abortion is violative of the Due Process Clause of the Fourteenth Amendment and the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."

The Stupak-Pitts amendment effectively reverses a women's control over her body. According to a 2002 study by the Guttmacher Institute, 90 percent of private policies currently cover abortion services. If this amendment is adopted, it will instantly modify the insurance coverage for the millions of women whose current insurance plans include coverage for abortion care. These women entered into their insurance contracts with the guarantee that potential abortions would be covered. Yet, if this amendment is passed, every women covered under the new health care system would have to purchase supplemental insurance or pay out of pocket for abortions. It is estimated that one third of Americans will have an abortion in their lifetime. If this amendment is adopted, thousands of women will be unable to afford a procedure for unpredictable and unwanted pregnancies. This would essentially be a ban on abortions for these women.

This is an unacceptable violation of a woman's personal sovereignty. I strongly oppose this amendment.

Ms. DEGETTE. Mr. Speaker, the gentleman from Pennsylvania said exactly what the intention is here. The intention is not simply to expand the Hyde amendment. The base bill does that. The base bill says that no Federal funds will be used in this bill for abortion.

It is the intention of our opponents to effectively stop a legal medical procedure from all plans that are in the exchange, even plans that are paid for with private dollars. This is the first time it would expand the Hyde exceptions to the private sector market. Mr. Speaker, it would not only affect the poor. It would affect the middle class.

Vote ''no'' on this ill-conceived amendment.

Ms. CHU. Mr. Speaker, I rise today in strong opposition to this amendment.

Ms. HIRONO. Mr. Speaker, I rise today in strong opposition to the Stupak Amendment, an amendment that is anti-choice and anti-women.

Earlier this week, I spoke about the importance of health care reform to women. If there was ever a group that has a lot at stake in reform, it is women. Health insurance companies today essentially treat being a woman as a pre-existing condition and charge them more for it. H.R. 3962 will put an end to the unjustifiable insurance practices of gender-rating—treating pregnancy, domestic violence, and previous c-section as pre-existing conditions—and not covering comprehensive maternity care. The men of this country would rise up in protest if they faced this kind of disparate treatment based on conditions particular to their gender.

The Stupak Amendment would effectively deny low-income women abortion coverage through insurance plans in the health insurance exchange. This is not only discriminatory but dangerous to women's health. Women without abortion coverage will be forced to postpone abortion care while attempting to raise the necessary funds—a delay that can exacerbate both the costs and the health risks of the procedure.

As a woman, I find it frankly insulting that the amendment would make women purchase additional insurance coverage for a legal medical procedure. We aren't asking individuals to purchase additional coverage in case they get cancer or in case they get diabetes. We aren't flagging out any other legal medical procedures to be treated in this manner.

Women do not plan to have unintended pregnancies or pregnancies with complications that create health risks. And yet unintended pregnancies and complications do arise. This amendment says it's okay to tell women, if you want to guard against these situations, go buy a rider. This is a deeply insulting attitude. An abortion rider policy also raises serious privacy concerns, as it fundamentally undermines the spirit of existing privacy law.

The sponsors of the amendment have consistently failed to highlight that the bill already contains a compromise that stipulates that state laws regarding abortion procedures are not pre-empted. The bill already states that no federal funds—neither tax nor cost sharing tax credits—can be used to pay for abortion procedures.

Before taking this vote, I urge my colleagues who support this amendment to think about the women in their lives, their mothers, sisters, daughters, granddaughters. Would they put the lives of these women at risk? Would they take away their fundamental rights of choice and freedom? Would they want to limit their access to any legal medical procedure? I ask these questions of my colleagues because in voting in support of the Stupak Amendment, they are answering yes to all these questions.

I urge my colleagues to join me in voting "no" on the amendment.

Ms. HARMAN. Mr. Speaker, It is going to be very difficult for me to vote for a health care bill that contains the Stupak amendment on abortion.

Far from codifying the Hyde language, which has been included in House appropriations bills since 1976, the Stupak amendment would essentially make it impossible for most women to use their own funds to purchase insurance to pay for abortions. This is not chipping away at a woman's right to choose, this is an outright assault on my constitutional rights—and it is wrong.

I respect the right of any woman or man to oppose abortion. But, in return, I expect those who are anti-choice to respect my views. My views are that abortion should be safe and rare—but that a woman's constitutional right to privacy as articulated in Roe v. Wade is inviolable.

I am old enough to remember the days of back alley abortions. Some women I know had them. I cannot bear the idea that the 111th Congress would restore that horror.

The Stupak amendment is insulting and destructive. Its passage would pair us with the government of Afghanistan in sending women's rights back to the Stone Age. I intend to vote for this bill, but if it contains the Stupak amendment when it emerges from Conference Committee, my conscience demands that I reconsider my support.

Ms. MCCOLLUM. Mr. Speaker, every member of this House has the right to their own opinions and views on issues related to health care reform—including women's reproductive health care issues. However, as comprehensive healthcare legislation reaches the House floor for a vote, Congress must not violate the first tenant of the entire reform effort, which is to ensure that no one loses healthcare coverage they currently have.

Today we have an amendment on the floor that bans legal reproductive health care services for woman who pay for their own health insurance. This amendment is wrong, it is dangerous, and it should be defeated.

The opportunity to meet the health care needs of all Americans is the strength of the bill we are debating. I want every American to have access to affordable, quality health care. This amendment and the work of many special interest groups to use this amendment to undermine health care reform is a transparent political game that puts millions of Americans at risk. Single issue political games must not be used to deny health care to millions of Americans.

I would like to submit for the RECORD a statement by a broad coalition of Minnesota religious leaders who call health care reform a matter of social justice that should not be undone by a single issue. These religious leaders understand the complex personal decision making that goes into health care choices, but they also know that Americans without access to health care too often have no choice except to suffer and too often endure conditions that result in severe illness or even preventable death.

These religious leaders are an inspiration to me. They are helping to frame the social, economic, moral and spiritual importance of passing health care reform legislation in Congress.

NOVEMBER 7, 2009.

As more Americans lose jobs and insurance coverage, health care reform bills are moving to final votes in Congress. Instead of working toward the reform that is so desperately needed, some groups, including the United States Conference of Catholic Bishops, are working overtime to ensure that women are denied the comprehensive health care they currently have.

With all the hyperbole, we have lost sight of the original goal of health reform: to expand access to health care, improve quality, and reduce costs—not to litigate abortion rights. As Congress works toward health care reform, they must make women's health a priority and guarantee that reproductive health care is covered.

Our faith traditions are abundantly clear about living in community with others and being responsible for them. Our traditions share the common core of serving those most in need. We join with others in expressing the need for us to return to the core of our faith traditions and realize that providing access to safe and quality health care makes sense morally, ethically, spiritually, and financially.

The president has repeatedly stated that no one should lose the coverage she or he currently has under health care reform. But, if dangerous amendments put forth by the vocal minority in Washington aren't defeated, women will lose their benefits, plain and simple.

It's simply untrue that abortion coverage will be mandated under the proposed new health plan. Simply put, Federal money would not pay for abortion care.

In fact, the House bill contains carefully crafted compromise language that allows women to keep the benefits they currently have while also ensuring that no federal funding is used for abortions.

Rep. Lois Capps drafted this provision to address both pro-life and pro-choice concerns around health care reform and balance both sides of the issue. The Capps proposal maintains the current policy of restricting federal funding for abortions and ensures that women won't lose benefits they currently have and will have access to insurance that covers abortion if they want it. Further, it expressly prohibits the use of federal funds to pay for abortion care.

This is an even-handed compromise supported by people on both sides of the issue. While reasonable people disagree over the issue of abortion, no woman wants her health to be the object of political gamesmanship in this debate. That's why the Capps proposal was created. It's a common sense solution to help health care reform move forward with the support of the mainstream on all sides of the issue.

As religious leaders, we support public policies that are just and compassionate and prioritize the needs of those who are poor and marginalized in our society. In this religiously pluralistic nation, our health care system should be inclusive and respectful of diverse religious beliefs and decisions regarding childbearing. A health care system that serves all persons with dignity and equality will include comprehensive reproductive health services.

Health care reform is far too important a social justice issue to be left to chance and overheated rhetoric. It's time to move forward for the good of American women and families.

Members and Friends of the Minnesota Religious Coalition for Reproductive Choice; Rev. Judith Allen Kim, Presbytery of the Twin Cities Area; The Rev. Norma Burton, Linden Hills United Church of Christ, Minneapolis; Kelli Clement, Candidate for Ministry, UUA; Rev. Doug Donley, University Baptist Church, Minneapolis; Rev. Dr. Rob Eller-Isaacs, and Rev. Dr. Janne Eller-Isaacs, Co-Ministers, Unity Church Unitarian, St. Paul; Rev. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Lockhart IV, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kiely Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Christine M. Smith, Cherokee Park United Church, St. Paul; Rev. Victoria Safford, White Bear Unitarian Universalist Church, Mahtomedi; Rabbi Jared Saks, Temple Israel, Minneapolis; Barbara Schmiechen, Linden Hills United Church of Christ, Minneapolis; and Rev. Daniel R. Schmiechen, Linden Hills United Church of Christ, Minneapolis.

Mr. MORAN of Kansas. Mr. Speaker, I rise in support of the Stupak-Pitts Amendment to H.R. 3962, Speaker PELOSI's health care reform bill. This amendment would maintain the current policy of preventing federal funding for abortion and for health benefits packages that include abortion. I feel a special obligation to protect innocent, young life.

I recently sponsored H. Con. Res. 169, legislation urging members of Congress to eliminate taxpayer-funded abortions from any proposed health care reform package. Directing taxpayer dollars to fund abortions is a clear violation of many Americans' deeply held beliefs and Americans should not be forced to compromise their core moral beliefs as a means to health care reform. Additionally, on September 28, 2009, I urged Speaker PELOSI and Democratic leadership, along with 182 of my House colleagues, to allow members of the House to vote their consciences with regard to abortion and health care reform by allowing consideration of an amendment to prohibit government funding of abortion.

Ms. BORDALLO. Mr. Speaker, I rise today in support of the Stupak-Ellsworth-Pitts-Smith-Kaptur-Dahlkemper Amendment to H.R. 3962 the ''Affordable Health Care for America Act.'' This amendment, supported by the United States Conference of Catholic Bishops, is important because it ensures that current federal law on abortion funding will apply to the public health care option created by H.R. 3962.

This amendment codifies the Hyde Amendment in H.R. 3962. It will prevent public funds from being used to pay for or subsidize elective abortions, either through the public option or heath care affordability tax credits, except in the case of rape, incest, physical injury or physical illness to the women. The Hyde Amendment is already in place in current federal health programs like Medicaid and Medicare and this amendment will make sure that H.R. 3962 is governed in a consistent manner.

I have received numerous letters from my constituents expressing both support for health care reform, but also grave concerns that federal funds would be used to pay for elective abortion under the new law. I am very supportive of the overall goals of H.R. 3962 and particularly its provisions that address the health disparity issues in the territories. The addition of the Stupak-Ellsworth-Pitts-Smith-Kaptur-Dahlkemper amendment will further strengthen this legislation and ensure that no one will need to choose between their conscientious objections to abortion and their desire to work toward more affordable quality health care in America.

I commend Congressman STUPAK for his leadership on this important issue and urge my colleagues to support this amendment.

Mr. FARR. Mr. Speaker, I rise to express my strong opposition to the Stupak-Pitts amendment.

The health care bill before the House tonight retains existing law on the ban on federal dollars being used for abortion services in federal programs. This health care bill does what it promised to do: not to expand abortion services. But the Stupak amendment wants to rewrite current law. This amendment ignores the constitutionally protected right for women to choose their reproductive health care. It makes women, and only women, have to purchase an additional policy with their own money to cover women's reproductive health care.

That we are considering outlawing a medical procedure—one chosen by patients and their doctors—in existing law. This amendment makes it impossible for women to purchase health care insurance to cover a health care procedure that can only be needed at a time of crisis. It would require women to plan for an unplanned pregnancy. That is plain wrong.

When will we stop treating women like second class citizens? When will we admit that they have the right to determine their health care like anyone else? Why are we boxing them in with this amendment that restricts and restrains their ability to act in a manner they deem appropriate for their well-being? Shame on us for being so disrespectful of their humanity and for attempting to disenfranchise them this way.

If we want health care for all Americans then women should be entitled to all health care, not just some aspects of it.

The SPEAKER pro tempore. The question is on the amendment offered by the gentleman from Michigan (Mr. STUPAK).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. STUPAK. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, further proceedings on this question will be postponed.

AMENDMENT OFFERED BY MR. BOEHNER

Mr. BOEHNER. Mr. Speaker, pursuant to the rule, I call up the amendment in the nature of a substitute printed in the rule.

The SPEAKER pro tempore (Mr. OBEY). The Clerk will designate the amendment.

The text of the amendment is as follows:

Part D amendment in the nature of a substitute printed in House Report 111–330 offered by Mr. BOEHNER:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Common Sense Health Care Reform and Affordability Act''.

(b) PURPOSE.—The purpose of this Act is to take meaningful steps to lower health care costs and increase access to health insurance coverage (especially for individuals with preexisting conditions) without—

(1) raising taxes;

(2) cutting Medicare benefits for seniors;

(3) adding to the national deficit;

(4) intervening in the doctor-patient relationship; or

(5) instituting a government takeover of health care.

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

(a) STATE REQUIREMENT.—

(1) IN GENERAL.—Not later than January 1, 2010, each State shall—

(A) subject to paragraph (3), operate—

(i) a qualified State reinsurance program described in subsection (b); or

(ii) qualifying State high risk pool described in subsection (c)(1); and

(B) subject to paragraph (3), apply to the operation of such a program from State funds an amount equivalent to the portion of State funds derived from State premium assessments (as defined by the Secretary) that are not otherwise used on State health care programs.

(2) RELATION TO CURRENT QUALIFIED HIGH RISK POOL PROGRAM.—

(A) STATES NOT OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is not operating a current section 2745 qualified high risk pool as of the date of the enactment of this Act—

(i) the State may only meet the requirement of paragraph (1) through the operation of a qualified State reinsurance program described in subsection (b); and

(ii) the State's operation of such a reinsurance program shall be treated, for purposes of section 2745 of the Public Health Service Act, as the operation of a qualified high risk pool described in such section.

(B) STATE OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is operating a current section 2745 qualified high risk pool as of the date of the enactment of this Act—

(i) as of January 1, 2010, such a pool shall not be treated as a qualified high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in subsection (c)(1); and

(ii) the State may use premium assessment funds described in paragraph (1)(B) to transition from operation of such a pool to operation of a qualified State reinsurance program described in subsection (b).

(3) APPLICATION OF FUNDS.—If the program or pool operated under paragraph (1)(A) is in strong fiscal health, as determined in accordance with standards established by the National Association of Insurance Commissioners and as approved by the State Insurance Commissioner involved, the requirement of paragraph (1)(B) shall be deemed to be met.

(b) QUALIFIED STATE REINSURANCE PROGRAM.—

(1) IN GENERAL.—For purposes of this section, a ''qualified State reinsurance program'' means a program operated by a State program that provides reinsurance for health insurance coverage offered in the small group market in accordance with the model for such a program established (as of the date of the enactment of this Act).

(2) FORM OF PROGRAM.—A qualified State reinsurance program may provide reinsurance—

(A) on a prospective or retrospective basis; and

(B) on a basis that protects health insurance issuers against the annual aggregate spending of their enrollees as well as purchase protection against individual catastrophic costs.

(3) SATISFACTION OF HIPAA REQUIREMENT.—A qualified State reinsurance program shall be deemed, for purposes of section 2745 of the Public Health Service Act, to be a qualified high-risk pool under such section.

(c) QUALIFYING STATE HIGH RISK POOL.—

(1) IN GENERAL.—A qualifying State high risk pool described in this subsection means a current section 2745 qualified high risk pool that meets the following requirements:

(A) The pool must provide at least two coverage options, one of which must be a high deductible health plan coupled with a health savings account.

(B) The pool must be funded with a stable funding source.

(C) The pool must eliminate any waiting lists so that all eligible residents who are seeking coverage through the pool should be allowed to receive coverage through the pool.

(D) The pool must allow for coverage of individuals who, but for the 24-month disability waiting period under section 226(b) of the Social Security Act, would be eligible for Medicare during the period of such waiting period.

(E) The pool must limit the pool premiums to no more than 150 percent of the average premium for applicable standard risk rates in that State.

(F) The pool must conduct education and outreach initiatives so that residents and brokers understand that the pool is available to eligible residents.

(G) The pool must provide coverage for preventive services and disease management for chronic diseases.

(2) VERIFICATION OF CITIZENSHIP OR ALIEN QUALIFICATION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, only citizens and nationals of the United States shall be eligible to participate in a qualifying State high risk pool that receives funds under section 2745 of the Public Health Service Act or this section.

(B) CONDITION OF PARTICIPATION.—As a condition of a State receiving such funds, the Secretary shall require the State to certify, to the satisfaction of the Secretary, that such State requires all applicants for coverage in the qualifying State high risk pool to provide satisfactory documentation of citizenship or nationality in a manner consistent with section 1903(x) of the Social Security Act.

(C) RECORDS.—The Secretary shall keep sufficient records such that a determination of citizenship or nationality only has to be made once for any individual under this paragraph.

(3) RELATION TO SECTION 2745.—As of January 1, 2010, a pool shall not qualify as qualified high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in paragraph (1).

(d) WAIVERS.—In order to accommodate new and innovative programs, the Secretary may waive such requirements of this section for qualified State reinsurance programs and for qualifying State high risk pools as the Secretary deems appropriate.

(e) FUNDING.—In addition to any other amounts appropriated, there is appropriated to carry out section 2745 of the Public Health Service Act (including through a program or pool described in subsection (a)(1))—

(1) $15,000,000,000 for the period of fiscal years 2010 through 2019; and

(2) an additional $10,000,000,000 for the period of fiscal years 2015 through 2019.

(f) DEFINITIONS.—In this section:

(1) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act.

(2) CURRENT SECTION 2745 QUALIFIED HIGH RISK POOL.—The term ''current section 2745 qualified high risk pool'' has the meaning given the term ''qualified high risk pool'' under section 2745(g) of the Public Health Service Act as in effect as of the date of the enactment of this Act.

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

(4) STANDARD RISK RATE.—The term ''standard risk rate'' means a rate that—

(A) is determined under the State high risk pool by considering the premium rates charged by other health insurance issuers offering health insurance coverage to individuals in the insurance market served;

(B) is established using reasonable actuarial techniques; and

(C) reflects anticipated claims experience and expenses for the coverage involved.

(5) STATE.—The term ''State'' means any of the 50 States or the District of Columbia.

SEC. 102. ELIMINATION OF CERTAIN REQUIREMENTS FOR GUARANTEED AVAILABILITY IN INDIVIDUAL MARKET.

(a) IN GENERAL.—Section 2741(b) of the Public Health Service Act (42 U.S.C. 300gg–41(b)) is amended——

(1) in paragraph (1)—

(A) by striking ''(1)(A)'' and inserting ''(1)''; and

(B) by striking ''and (B)'' and all that follows up to the semicolon at the end;

(2) by adding ''and'' at the end of paragraph (2);

(3) in paragraph (3)—

(A) by striking ''(1)(A)'' and inserting ''(1)''; and

(B) by striking the semicolon at the end and inserting a period; and

(4) by striking paragraphs (4) and (5).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 103. NO ANNUAL OR LIFETIME SPENDING CAPS.

Notwithstanding any other provision of law, a health insurance issuer (including an entity licensed to sell insurance with respect to a State or group health plan) may not apply an annual or lifetime aggregate spending cap on any health insurance coverage or plan offered by such issuer.

SEC. 104. PREVENTING UNJUST CANCELLATION OF INSURANCE COVERAGE.

(a) CLARIFICATION REGARDING APPLICATION OF GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42) is amended—

(1) in its heading, by inserting ''**, continuation in force, including prohibition of rescission,**'' after ''**guaranteed renewability**'';

(2) in subsection (a), by inserting '', including without rescission,'' after ''continue in force''; and

(3) in subsection (b)(2), by inserting before the period at the end the following: '', including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed''.

(b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

''(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

''(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply after the date of the enactment of this Act with respect to health insurance coverage issued before, on, or after such date.

TITLE II—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

SEC. 111. STATE INNOVATION PROGRAMS.

(a) PROGRAMS THAT REDUCE THE COST OF HEALTH INSURANCE PREMIUMS.—

(1) PAYMENTS TO STATES.—

(A) FOR PREMIUM REDUCTIONS IN THE SMALL GROUP MARKET.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the small group market in year 3, in year 6, or year 9 (as defined in subsection (c)) below the premium baseline for such year (as defined paragraph (2)), the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage (as defined in paragraph (3)) for the State, market, and year; and

(ii) the maximum State premium payment amount (as defined in paragraph (4)) for the State, market, and year

(B) FOR PREMIUM REDUCTIONS IN THE INDIVIDUAL MARKET.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the individual market in year 3, in year 6, or in year 9 below the premium baseline for such year, the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage for the State, market, and year; and

(ii) the maximum State premium payment amount for the State, market, and year.

(2) PREMIUM BASELINE.—For purposes of this subsection, the term ''premium baseline'' means, for a market in a State—

(A) for year 1, the average per capita premiums for health insurance coverage in such market in the State in such year; or

(B) for a subsequent year, the baseline for the market in the State for the previous year under this paragraph increased by a percentage specified in accordance with a formula established by the Secretary, in consultation with the Congressional Budget Office and the Bureau of the Census, that takes into account at least the following:

(i) GROWTH FACTOR.—The inflation in the costs of inputs to health care services in the year.

(ii) HISTORIC PREMIUM GROWTH RATES.—Historic growth rates, during the 10 years before year 1, of per capita premiums for health insurance coverage.

(iii) DEMOGRAPHIC CONSIDERATIONS.—Historic average changes in the demographics of the population covered that impact on the rate of growth of per capita health care costs.

(3) BONUS PREMIUM PERCENTAGE DEFINED.—

(A) IN GENERAL.—For purposes of this subsection, the term ''bonus premium percentage'' means, for the small group market or individual market in a State for a year, such percentage as determined in accordance with the following table based on the State's premium performance level (as defined in subparagraph (B)) for such market and year:

The bonus premium percentage for a State is—	For year 3 if the premium performance level of the State is—	For year 6 if the premium performance level of the State is—	For year 9 if the premium performance level of the State is—
100 percent	at least 8.5%	at least 11%	at least 13.5%
50 percent	at least 6.38%, but less than 8.5%	at least 10.38%, but less than 11%	at least 12.88%, but less than 13.5%
25 percent	at least 4.25%, but less than 6.38%	at least 9.75%, but less than 10.38%	at least 12.25%, but less than 12.88%
0 percent	less than 4.25%	less than 9.75%	less than 12.25%

(B) PREMIUM PERFORMANCE LEVEL.—For purposes of this subsection, the term ''premium performance level'' means, for a State, market, and year, the percentage reduction in the average per capita premiums for health insurance coverage for the State, market, and year, as compared to the premium baseline for such State, market, and year.

(4) MAXIMUM STATE PREMIUM PAYMENT AMOUNT DEFINED.—For purposes of this subsection, the term ''maximum State premium payment amount'' means, for a State for the small group market or the individual market for a year, the product of—

(A) the proportion (as determined by the Secretary), of the number of nonelderly individuals lawfully residing in all the States who are enrolled in health insurance coverage in the respective market in the year, who are residents of the State; and

(B) the amount available for obligation from amounts appropriated under subsection (d) for such market with respect to performance in such year.

(5) METHODOLOGY FOR CALCULATING AVERAGE PER CAPITA PREMIUMS.—

(A) ESTABLISHMENT.—The Secretary shall establish, by rule and consistent with this subsection, a methodology for computing the average per capita premiums for health insurance coverage for the small group market and for the individual market in each State for each year beginning with year 1.

(B) ADJUSTMENTS.—Under such methodology, the Secretary shall provide for the following adjustments (in a manner determined appropriate by the Secretary):

(i) EXCLUSION OF ILLEGAL ALIENS.—An adjustment so as not to take into account enrollees who are not lawfully present in the United States and their premium costs.

(ii) TREATING STATE PREMIUM SUBSIDIES AS PREMIUM COSTS.—An adjustment so as to increase per capita premiums to remove the impact of premium subsidies made directly by a State to reduce health insurance premiums.

(6) CONDITIONS OF PAYMENT.—As a condition of receiving a payment under paragraph (1), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary to determine the State's premium baseline and premium performance level for purposes of this subsection.

(b) PROGRAMS THAT REDUCE THE NUMBER OF UNINSURED.—

(1) IN GENERAL.—If the Secretary determines that a State has reduced the percentage of uninsured nonelderly residents in year 5, year 7, or year 9, below the uninsured baseline (as defined in paragraph (2)) for the State for the year, the Secretary shall pay the State an amount equal to the product of—

(A) bonus uninsured percentage (as defined in paragraph (3)) for the State and year; and

(B) the maximum uninsured payment amount (as defined in paragraph (4)) for the State and year.

(2) UNINSURED BASELINE.—

(A) IN GENERAL.—For purposes of this subsection, and subject to subparagraph (B), the term ''uninsured baseline'' means, for a State, the percentage of nonelderly residents in the State who are uninsured in year 1.

(B) ADJUSTMENT.—The Secretary may, at the written request of a State, adjust the uninsured baseline for States for a year to take into account unanticipated and exceptional changes, such as an unanticipated migration, of nonelderly individuals into, or out of, States in a manner that does not reflect substantially the proportion of uninsured nonelderly residents in the States involved in year 1. Any such adjustment shall only be done in a manner that does not result in the average of the uninsured baselines for nonelderly residents for all States being changed.

(3) BONUS UNINSURED PERCENTAGE.—

(A) BONUS UNINSURED PERCENTAGE.—For purposes of this subsection, the term ''bonus uninsured percentage'' means, for a State for a year, such percentage as determined in accordance with the following table, based on the uninsured performance level (as defined in subparagraph (B)) for such State and year:

The bonus uninsured percentage for a State is—	For year 5 if the uninsured performance level of the State is—	For year 7 if the uninsured performance level of the State is—	For year 9 if the uninsured performance level of the State is—
100 percent	at least 10%	at least 15%	at least 20%
50 percent	at least 7.5% but less than 10%	at least 13.75% but less than 15%	at least 18.75% but less than 20%
25 percent	at least 5% but less than 7.5%	at least 12.5% but less than 13.75%	at least 17.5% but less than 18.75%
0 percent	less than 5%	less than 12.5%	less than 17.5%

(B) UNINSURED PERFORMANCE LEVEL.—For purposes of this subsection, the term ''uninsured performance level'' means, for a State for a year, the reduction (expressed as a percentage) in the percentage of uninsured nonelderly residents in such State in the year as compared to the uninsured baseline for such State for such year.

(4) MAXIMUM STATE UNINSURED PAYMENT AMOUNT DEFINED.—For purposes of this subsection, the term ''maximum State uninsured payment amount'' means, for a State for a year, the product of—

(A) the proportion (as determined by the Secretary), of the number of uninsured nonelderly individuals lawfully residing in all the States in the year, who are residents of the State; and

(B) the amount available for obligation under this subsection from amounts appropriated under subsection (d) with respect to performance in such year.

(5) METHODOLOGY FOR COMPUTING THE PERCENTAGE OF UNINSURED NONELDERLY RESIDENTS IN A STATE.—

(A) ESTABLISHMENT.—The Secretary shall establish, by rule and consistent with this subsection, a methodology for computing the percentage of nonelderly residents in a State who are uninsured in each year beginning with year 1.

(B) RULES.—

(i) TREATMENT OF UNINSURED.—Such methodology shall treat as uninsured those residents who do not have health insurance coverage or other creditable coverage (as defined in section 9801(c)(1) of the Internal Revenue Code of 1986), except that such methodology shall rely upon data on the nonelderly and uninsured populations within each State in such year provided through population surveys conducted by federal agencies.

(ii) LIMITATION TO NONELDERLY.—Such methodology shall exclude individuals who are 65 years of age or older.

(iii) EXCLUSION OF ILLEGAL ALIENS.—Such methodology shall exclude individuals not lawfully present in the United States.

(6) CONDITIONS OF PAYMENT.—As a condition of receiving a payment under paragraph (1), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary in determining the State's uninsured baseline and uninsured performance level for purposes of this subsection.

(c) DEFINITIONS.—For purposes of this section:

(1) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 9832(a) of the Internal Revenue Code of 1986.

(2) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' has the meaning given such term in section 9832(b)(1) of the Internal Revenue Code of 1986.

(3) INDIVIDUAL MARKET.—Except as the Secretary may otherwise provide in the case of group health plans that have fewer than 2 participants as current employees on the first day of a plan year, the term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

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

(5) SMALL GROUP MARKET.—The term ''small group market'' means the market for health insurance coverage under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer who employed on average at least 2 but not more than 50 employees on business days during a calendar year.

(6) STATE.—The term ''State'' means any of the 50 States and the District of Columbia.

(7) YEARS.—The terms ''year 1'', ''year 2'', ''year 3'', and similar subsequently numbered years mean 2010, 2011, 2012, and subsequent sequentially numbered years.

(d) APPROPRIATIONS; PAYMENTS.—

(1) PAYMENTS FOR REDUCTIONS IN COST OF HEALTH INSURANCE COVERAGE.—

(A) SMALL GROUP MARKET.—

(i) IN GENERAL.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(A)—

(I) $18,000,000,000 with respect to performance in year 3;

(II) $5,000,000,000 with respect to performance in year 6; and

(III) $2,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(B) INDIVIDUAL MARKET.—

(i) IN GENERAL.—Subject to clause (ii), from any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(B)—

(I) $7,000,000,000 with respect to performance in year 3;

(II) $2,000,000,000 with respect to performance in year 6; and

(III) $1,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Of the funds appropriated under clause (i) that are not expended or obligated by the end of the year following the year for which the funds are appropriated—

(I) 75 percent shall remain available until expended for payments under subsection (a)(1)(B); and

(II) 25 percent shall remain available until expended for payments under subsection (a)(1)(A).

(2) PAYMENTS FOR REDUCTIONS IN THE PERCENTAGE OF UNINSURED.—

(A) IN GENERAL.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (b)(1)—

(i) $10,000,000,000 with respect to performance in year 5;

(ii) $3,000,000,000 with respect to performance in year 7; and

(iii) $2,000,000,000 with respect to performance in year 9

(B) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under subparagraph (A) shall remain available until expended.

(3) PAYMENT TIMING.—Payments under this section shall be made in a form and manner specified by the Secretary in the year after the performance year involved.

SEC. 112. HEALTH PLAN FINDERS.

(a) STATE PLAN FINDERS.—Not later than 12 months after the date of the enactment of this Act, each State may contract with a private entity to develop and operate a plan finder website (referred to in this section as a ''State plan finder'') which shall provide information to individuals in such State on plans of health insurance coverage that are available to individuals in such State (in this section referred to as a ''health insurance plan''). Such State may not operate a plan finder itself.

(b) MULTI-STATE PLAN FINDERS.—

(1) IN GENERAL.—A private entity may operate a multi-State finder that operates under this section in the States involved in the same manner as a State plan finder would operate in a single State.

(2) SHARING OF INFORMATION.—States shall regulate the manner in which data is shared between plan finders to ensure consistency and accuracy in the information about health insurance plans contained in such finders.

(c) REQUIREMENTS FOR PLAN FINDERS.—Each plan finder shall meet the following requirements:

(1) The plan finder shall ensure that each health insurance plan in the plan finder meets the requirements for such plans under subsection (d).

(2) The plan finder shall present complete information on the costs and benefits of health insurance plans (including information on monthly premium, copayments, and deductibles) in a uniform manner that—

(A) uses the standard definitions developed under paragraph (3); and

(B) is designed to allow consumers to easily compare such plans.

(3) The plan finder shall be available on the internet and accessible to all individuals in the State or, in the case of a multi-State plan finder, in all States covered by the multi-State plan finder.

(4) The plan finder shall allow consumers to search and sort data on the health insurance plans in the plan finder on criteria such as coverage of specific benefits (such as coverage of disease management services or pediatric care services), as well as data available on quality.

(5) The plan finder shall meet all relevant State laws and regulations, including laws and regulations related to the marketing of insurance products. In the case of a multi-State plan finder, the finder shall meet such laws and regulations for all of the States involved.

(6) The plan finder shall meet solvency, financial, and privacy requirements established by the State or States in which the plan finder operates or the Secretary for multi-State finders.

(7) The plan finder and the employees of the plan finder shall be appropriately licensed in the State or States in which the plan finder operates, if such licensure is required by such State or States.

(8) Notwithstanding subsection (f)(1), the plan finder shall assist individuals who are eligible for the Medicaid program under title XIX of the Social Security Act or State Children's Health Insurance Program under title XXI of such Act by including information on Medicaid options, eligibility, and how to enroll.

(d) REQUIREMENTS FOR PLANS PARTICIPATING IN A PLAN FINDER.—

(1) IN GENERAL.—Each State shall ensure that health insurance plans participating in the State plan finder or in a multi-State plan finder meet the requirements of paragraph (2) (relating to adequacy of insurance coverage, consumer protection, and financial strength).

(2) SPECIFIC REQUIREMENTS.—In order to participate in a plan finder, a health insurance plan must meet all of the following requirements, as determined by each State in which such plan operates:

(A) The health insurance plan shall be actuarially sound.

(B) The health insurance plan may not have a history of abusive policy rescissions.

(C) The health insurance plan shall meet financial and solvency requirements.

(D) The health insurance plan shall disclose—

(i) all financial arrangements involving the sale and purchase of health insurance, such as the payment of fees and commissions; and

(ii) such arrangements may not be abusive.

(E) The health insurance plan shall maintain electronic health records that comply with the requirements of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) related to electronic health records.

(F) The health insurance plan shall make available to plan enrollees via the finder, whether by information provided to the finder or by a website link directing the enrollee from the finder to the health insurance plan website, data that includes the price and cost to the individual of services offered by a provider according to the terms and conditions of the health plan. Data described in this paragraph is not made public by the finder, only made available to the individual once enrolled in the health plan.

(e) PROHIBITIONS.—

(1) DIRECT ENROLLMENT.—The State plan finder may not directly enroll individuals in health insurance plans.

(2) CONFLICTS OF INTEREST.—

(A) COMPANIES.—A health insurance issuer offering a health insurance plan through a plan finder may not—

(i) be the private entity developing and maintaining a plan finder under subsections (a) and (b); or

(ii) have an ownership interest in such private entity or in the plan finder.

(B) INDIVIDUALS.—An individual employed by a health insurance issuer offering a health insurance plan through a plan finder may not serve as a director or officer for—

(i) the private entity developing and maintaining a plan finder under subsections (a) and (b); or

(ii) the plan finder.

(f) CONSTRUCTION.—Nothing in this section shall be construed to allow the Secretary authority to regulate benefit packages or to prohibit health insurance brokers and agents from—

(1) utilizing the plan finder for any purpose; or

(2) marketing or offering health insurance products.

(g) PLAN FINDER DEFINED.—For purposes of this section, the term ''plan finder'' means a State plan finder under subsection (a) or a multi-State plan finder under subsection (b).

(h) STATE DEFINED.—In this section, the term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

SEC. 113. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.''; and

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

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction described in subsection (a)(2) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall rely on recommendations for operating rules developed by a qualified nonprofit entity, as selected by the Secretary, that meets the following requirements:

''(A) The entity focuses its mission on administrative simplification.

''(B) The entity demonstrates an established multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has established a public set of guiding principles that ensure the operating rules and process are open and transparent.

''(D) The entity coordinates its activities with the HIT Policy Committee and the HIT Standards Committee (as established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

''(E) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(F) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(G) The entity allows for public review and updates of the operating rules.

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) review the operating rules developed by a nonprofit entity described under paragraph (2);

''(B) determine whether such rules represent a consensus view of the health care industry and are consistent with and do not alter current standards;

''(C) evaluate whether such rules are consistent with electronic standards adopted for health information technology; and

''(D) submit to the Secretary a recommendation as to whether the Secretary should adopt such rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(D) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for transactions for eligibility for a health plan and health claim status shall be adopted not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than July 1, 2012, in a manner ensuring that such rules are effective not later than January 1, 2014.

''(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2014, in a manner ensuring that such rules are effective not later than January 1, 2016.

''(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) OTHER COMPLETED TRANSACTIONS.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

''(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

''(3) SERVICE CONTRACTS.—A health plan shall be required to comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection for any entities that provide services pursuant to a contract with such health plan.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may contract with an independent, outside entity to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND RULES.—A health plan (including entities described under paragraph (3)) shall comply with the certification and documentation requirements under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that amends any standard or operating rule described under paragraph (1) of this subsection. A health plan shall comply with such requirements not later than the effective date of the applicable interim final rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND RULES.—

''(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

''(2) EVALUATIONS AND REPORTS.—

''(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the existing standards and operating rules established under this section.

''(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

''(3) INTERIM FINAL RULEMAKING.—

''(A) IN GENERAL.—Any recommendations to amend existing standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

''(B) PUBLIC COMMENT.—

''(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

''(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

''(4) REVIEW COMMITTEE.—

''(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

''(i) the National Committee on Vital and Health Statistics; or

''(ii) any appropriate committee as determined by the Secretary.

''(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

''(j) PENALTIES.—

''(1) PENALTY FEE.—

''(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection.

''(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

''(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

''(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

''(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

''(i) an amount equal to $20 per covered life under such plan; or

''(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

''(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

''(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

''(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

''(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

''(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

''(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

''(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6601 of the Internal Revenue Code of 1986; and

''(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

''(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.''.

(b) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (a)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(c) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

(d) MEDICARE AND MEDICAID COMPLIANCE REPORTS.—Not later than July 1, 2013, the Secretary of Health and Human Services shall submit a report to the Chairs and Ranking Members of the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Chairs and Ranking Members of the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate on the extent to which the Medicare program and providers that serve beneficiaries under that program, and State Medicaid programs and providers that serve beneficiaries under those programs, transact electronically in accordance with transaction standards issued under the Health Insurance Portability and Accountability Act of 1996, part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

DIVISION B—IMPROVING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

''(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2009,

''(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

''(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending

with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2009.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2009, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

''(1) the affiliated member was an affiliated member on the date of certification under this part; or

''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

''(i) setting contribution rates based on the claims experience of the plan; or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect

to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage; or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions;

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

''(iii) a reserve sufficient for any other obligations of the plan; and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess/stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan's projected levels of participation or claims, the nature of the plan's liabilities, and the types of assets available to assure that such liabilities are met.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination

pursuant to section 809(b) (relating to mandatory termination);

''(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2009, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

''(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

''(A) a representative of the National Association of Insurance Commissioners;

''(B) a representative of the American Academy of Actuaries;

''(C) a representative of the State governments, or their interests;

''(D) a representative of existing self-insured arrangements, or their interests;

''(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

''(F) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation such interim reports as it considers appropriate.

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the

applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary, and applicable provisions of law;

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

''(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

''(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2009.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

''(3) such tax is otherwise nondiscriminatory; and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

''(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2009, a person eligible to be a member of the sponsor or one of its member associations.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

''(A) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

''(B) relating to prompt payment of claims.

''(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(5) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 812, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2009 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended

by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''801. Association health plans.
''802. Certification of association health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''807. Requirements for application and related requirements.
''808. Notice requirements for voluntary termination.
''809. Corrective actions and mandatory termination.
''810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''811. State assessment authority.
''812. Definitions and rules of construction.''.

SEC. 202. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after ''control group,'' the following: ''except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,'';

(2) in clause (iii), by striking ''(iii) the determination'' and inserting the following:

''(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, an interest of greater than 25 percent may not be required as the minimum interest necessary for common control, or

''(II) in any other case, the determination'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 203. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''Sec. 501.''; and

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

''(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement described in section 3(40)(A)(i),

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a) IN GENERAL.—'' before ''In accordance'', and by adding at the end the following new subsection:

''(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 204. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

''(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

''(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 205. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 1 year after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

SEC. 211. EXTENDING COVERAGE OF DEPENDENTS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 2714 the following new section:

''SEC. 715. EXTENDING COVERAGE OF DEPENDENTS.

''(a) IN GENERAL.—In the case of a group health plan, or health insurance coverage offered in connection with a group health plan, that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan or coverage shall continue to treat the individual as a dependent child without regard to the individual's age through at least the end of the plan year in which the individual turns an age specified in the plan, but not less than 25 years of age.

''(b) CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide benefits for dependent children as beneficiaries under the plan or to require a participant to elect coverage of dependent children.''.

(2) CLERICAL AMENDMENT.—The table of contents of such Act is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Extending coverage of dependents through plan year that includes 25th birthday.''.

(b) PHSA.—Title XXVII of the Public Health Service Act is amended by inserting after section 2707 the following new section:

''SEC. 2708. EXTENDING COVERAGE OF DEPENDENTS.

''(a) IN GENERAL.—In the case of a group health plan, or health insurance coverage offered in connection with a group health plan, that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan or coverage shall continue to treat the individual as a dependent child without regard to the individual's age through at least the end of the plan year in which the individual turns an age specified in the plan, but not less than 25 years of age.

''(b) CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide benefits for dependent children as beneficiaries under the plan or to require a participant to elect coverage of dependent children.''.

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9814. EXTENDING COVERAGE OF DEPENDENTS.

''(a) IN GENERAL.—In the case of a group health plan that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan shall continue to treat the individual as a dependent child without regard to the individual's age through at least the end of the plan year in which the individual turns an age specified in the plan, but not less than 25 years of age.

''(b) CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide coverage for dependent children as beneficiaries under the plan or to require a participant to elect coverage of dependent children.''.

(2) CLERICAL AMENDMENT.—The table of sections in such subchapter is amended by adding at the end the following new item:

''Sec. 9814. Extending coverage of dependents through plan year that includes 25th birthday.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to group health plans for plan years beginning more than 3 months after the date of the enactment of this Act and shall apply to individuals who are dependent children under a group health plan, or health insurance coverage offered in connection with such a plan, on or after such date.

SEC. 212. ALLOWING AUTO-ENROLLMENT FOR EMPLOYER SPONSORED COVERAGE.

(a) IN GENERAL.—No State shall establish a law that prevents an employer from instituting auto-enrollment for coverage of a participant or beneficiary, including current employees, under a group health plan, or health insurance coverage offered in connection with such a plan, so long as the participant or beneficiary has the option of declining such coverage.

(b) AUTOENROLLMENT.—

(1) NOTICE REQUIRED.—Employers with auto-enrollment under a group health plan or health insurance coverage shall provide annual notification, within a reasonable period before the beginning of each plan year, to each employee eligible to participate in the plan. The notice shall explain the employee contribution to such plan and the employee's right to decline coverage.

(2) TREATMENT OF NON-ACTION.—After a reasonable period of time after receipt of the notice, if an employee fails to make an affirmative declaration declining coverage, then such an employee may be enrolled in the group health plan or health insurance coverage offered in connection with such a plan.''

(c) CONSTRUCTION.—Nothing in this section shall be construed to supersede State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll or the sponsoring of employer sponsored health insurance coverage except to the extent that such standard or requirement prevents an employer from instituting the auto-enrollment described in subsection (a).

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO BUY HEALTH CARE COVERAGE ACROSS STATE LINES

SEC. 221. INTERSTATE PURCHASING OF HEALTH INSURANCE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

''PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

''SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

''(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

''(B) to pay other obligations in the normal course of business.

''(7) COVERED LAWS.—

''(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

''(i) individual health insurance coverage issued by a health insurance issuer;

''(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

''(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

''(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

''(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

''(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement,

or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

''(8) STATE.—The term 'State' means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

''(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

''(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

''(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

''(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

''(E) Refusing to pay claims without conducting a reasonable investigation.

''(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

''(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

''(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

''(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

''(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

''(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

''(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

''(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

''SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

''(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

''(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

''(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

''(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

''(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

''(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

''(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

THIS POLICY IS ISSUED BY _____ **AND IS GOVERNED BY THE LAWS AND REGULATIONS OF THE STATE OF _____, AND IT HAS MET ALL THE LAWS OF THAT STATE AS DETERMINED BY THAT STATE'S DEPARTMENT OF INSURANCE. THIS POLICY MAY BE LESS EXPENSIVE THAN OTHERS BECAUSE IT IS NOT SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF THE STATE OF _____, INCLUDING COVERAGE OF SOME SERVICES OR BENEFITS MANDATED BY THE LAW OF THE STATE OF _____. ADDITIONALLY, THIS POLICY IS NOT SUBJECT TO ALL OF THE CONSUMER PROTECTION LAWS OR RESTRICTIONS ON RATE CHANGES OF THE STATE OF _____. AS WITH ALL INSURANCE PRODUCTS, BEFORE PURCHASING THIS POLICY, YOU SHOULD CAREFULLY REVIEW THE POLICY AND DETERMINE WHAT HEALTH CARE SERVICES THE POLICY COVERS AND WHAT BENEFITS IT PROVIDES, INCLUDING ANY EXCLUSIONS, LIMITATIONS, OR CONDITIONS FOR SUCH SERVICES OR BENEFITS.**''.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

''(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

''(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

''(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

''(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

''(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

''(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

''(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

''(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

''(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

''(j) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

''SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

''(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

''(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

''(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a)(2)—

''(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

''(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

''(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

''(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

''(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

''(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

''(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice

within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

''(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

''(B) not be contingent on the decision rendered by the reviewer.

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

''(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

''(B) The enrollee (or authorized representative).

''(C) The health care professional that provides the items or services involved in the denial.

''(D) The institution at which the items or services (or treatment) involved in the denial are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

''(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''SEC. 2799. ENFORCEMENT.

''(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

''(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

''(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

''(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

SEC. 231. SAVER'S CREDIT FOR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.

(a) ALLOWANCE OF CREDIT.—Subsection (a) of section 25B of the Internal Revenue Code of 1986 is amended by inserting ''aggregate qualified HSA contributions and'' after ''so much of the''.

(b) QUALIFIED HSA CONTRIBUTIONS.—Subsection (d) of section 25B of such Code is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) QUALIFIED HSA CONTRIBUTIONS.—The term 'qualified HSA contribution' means, with respect to any taxable year, a contribution of the eligible individual to a health savings account (as defined in section 223(d)(1)) for which a deduction is allowable under section 223(a) for such taxable year.''.

(c) CONFORMING AMENDMENT.—The first sentence of section 25B(d)(3)(A) of such Code (as redesignated by subsection (b)) is amended to read as follows: ''The aggregate qualified retirement savings contributions determined under paragraph (1) and qualified HSA contributions determined under paragraph (2) shall be reduced (but not below zero) by the aggregate distributions received by the individual during the testing period from any entity of a type to which contributions under paragraph (1) or paragraph (2) (as the case may be) may be made.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions made after December 31, 2009.

SEC. 232. HSA FUNDS FOR PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following:

''(v) a high deductible health plan if—

''(I) such plan is not offered in connection with a group health plan,

''(II) no portion of any premium (within the meaning of applicable premium under section 4980B(f)(4)) for such plan is excludable from gross income under section 106, and

''(III) the account beneficiary demonstrates, using procedures deemed appropriate by the Secretary, that after payment of the premium for such insurance the balance in the health savings account is at least twice the minimum deductible in effect under subsection (c)(2)(A)(i) which is applicable to such plan.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for a high deductible health plan for periods beginning after December 31, 2009.

SEC. 233. REQUIRING GREATER COORDINATION BETWEEN HDHP ADMINISTRATORS AND HSA ACCOUNT ADMINISTRATORS SO THAT ENROLLEES CAN ENROLL IN BOTH AT THE SAME TIME.

The Secretary of the Treasury, through the issuance of regulations or other guidance, shall encourage administrators of health plans and trustees of health savings accounts to provide for simultaneous enrollment in high deductible health plans and setup of health savings accounts.

SEC. 234. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.

(a) IN GENERAL.—Subsection (d) of section 223 of the Internal Revenue Code of 1986 is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

''(4) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—

''(A) IN GENERAL.—For purposes of paragraph (2), an expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred during the 60-day period beginning on the date on which the high deductible health plan is first effective.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) an individual shall be treated as an eligible individual for any portion of a month for which the individual is described in subsection (c)(1), determined without regard to whether the individual is covered under a high deductible health plan on the 1st day of such month, and

''(ii) the effective date of the health savings account is deemed to be the date on which the high deductible health plan is first effective after the date of the enactment of this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

SEC. 301. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 302. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing

in this title shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 303. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 304. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 305. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 306. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 307. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 308. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 309. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this title or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this title shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 302(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 310. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 401. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to interfere with the doctor-patient relationship or the practice of medicine.

SEC. 402. REPEAL OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Effective on the date of the enactment of this Act, section 804 of the American Recovery and Reinvestment Act of 2009 is repealed.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

SEC. 501. INCENTIVES FOR PREVENTION AND WELLNESS PROGRAMS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 LIMITATION ON EXCEPTION FOR WELLNESS PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

(1) IN GENERAL.—Section 702(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)(2)) is amended by adding after and below subparagraph (B) the following:

''In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO PHSA.—

(1) GROUP MARKET RULES.—

(A) IN GENERAL.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(2)) is amended by adding after and below subparagraph (B) the following:

''In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

(2) INDIVIDUAL MARKET RULES RELATING TO GUARANTEED AVAILABILITY.—

(A) IN GENERAL.—Section 2741(f) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(2)) is amended by adding after and below paragraph (1) the following:

''In applying paragraph (2), a health insurance issuer may vary premiums and cost-sharing under health insurance coverage by up to 50 percent of the value of the benefits under the coverage based on participation in a standards-based wellness program.''.

(B) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to health insurance coverage offered or renewed on and after the date that is 1 year after the date of the enactment of this Act.

(c) CONFORMING AMENDMENTS TO IRC.—

(1) IN GENERAL.—Section 9802(b)(2) of the Internal Revenue Code of 1986 is amended by adding after and below subparagraph (B) the following:

''In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

DIVISION F—PROTECTING TAXPAYERS

SEC. 601. PROVIDE FULL FUNDING TO HHS OIG AND HCFAC.

(a) HCFAC FUNDING.— Section 1817(k)(3)(A) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (IV), by striking ''2009, and 2010'' and inserting ''and 2009''; and

(B) by amending subclause (V) to read as follows:

''(V) for each fiscal year after fiscal year 2009, $300,000,000.''; and

(2) in clause (ii)—

(A) in subclause (IX), by striking ''2009, and 2010'' and inserting ''and 2009''; and

(B) in subclause (X), by striking ''2010'' and inserting ''2009'' and by inserting before the period at the end the following: '', plus the amount by which the amount made available under clause (i)(V) for fiscal year 2010 exceeds the amount made available under clause (i)(IV) for 2009''.

(b) OIG FUNDING.—There are authorized to be appropriated for each of fiscal years 2010 through 2019 $100,000,000 for the Office of the Inspector General of the Department of Health and Human Services for fraud prevention activities under the Medicare and Medicaid programs.

SEC. 602. PROHIBITING TAXPAYER FUNDED ABORTIONS AND CONSCIENCE PROTECTIONS.

Title 1 of the United States Code is amended by adding at the end the following new chapter:

''CHAPTER 4—PROHIBITING TAXPAYER FUNDED ABORTIONS AND CONSCIENCE PROTECTIONS

''SEC. 301. PROHIBITION ON FUNDING FOR ABORTIONS.

''No funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for any abortion.

''SEC. 302. PROHIBITION ON FUNDING FOR HEALTH BENEFITS PLANS THAT COVER ABORTION.

''None of the funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for a health benefits plan that includes coverage of abortion.

''SEC. 303. TREATMENT OF ABORTIONS RELATED TO RAPE, INCEST, OR PRESERVING THE LIFE OF THE MOTHER.

''The limitations established in sections 301 and 302 shall not apply to an abortion—

''(1) if the pregnancy is the result of an act of rape or incest; or

''(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

''SEC. 304. CONSTRUCTION RELATING TO SUPPLEMENTAL COVERAGE.

''Nothing in this chapter shall be construed as prohibiting any individual, entity, or State or locality from purchasing separate supplemental abortion plan or coverage that includes abortion so long as such plan or coverage is paid for entirely using only funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

''SEC. 305. CONSTRUCTION RELATING TO THE USE OF NON-FEDERAL FUNDS FOR HEALTH COVERAGE.

''Nothing in this chapter shall be construed as restricting the ability of any managed care provider or other organization from offering abortion coverage or the ability of a State to contract separately with such a provider or organization for such coverage with funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

''SEC. 306. NO GOVERNMENT DISCRIMINATION AGAINST CERTAIN HEALTH CARE ENTITIES.

''(a) IN GENERAL.—No funds authorized or appropriated by federal law may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

''(b) HEALTH CARE ENTITY DEFINED.—For purposes of this section, the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.''.

SEC. 603. IMPROVED ENFORCEMENT OF THE MEDICARE AND MEDICAID SECONDARY PAYER PROVISIONS.

(a) MEDICARE.—

(1) IN GENERAL.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall provide through the Coordination of Benefits Contractor for the identification of instances where the Medicare program should be, but is not, acting as a secondary payer to an individual's private health benefits coverage under section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)).

(2) UPDATING PROCEDURES.—The Secretary shall update procedures for identifying and resolving credit balance situations which occur under the Medicare program when payment under such title and from other health benefit plans exceed the providers' charges or the allowed amount.

(3) REPORT ON IMPROVED ENFORCEMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on progress made in improved enforcement of the Medicare secondary payer provisions, including recoupment of credit balances.

(b) MEDICAID.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) ENFORCEMENT OF PAYER OF LAST RESORT PROVISIONS.—

''(1) SUBMISSION OF STATE PLAN AMENDMENT.—Each State shall submit, not later than 1 year after the date of the enactment of this subsection, a State plan amendment that details how the State will become fully compliant with the requirements of section 1902(a)(25).

''(2) BONUS FOR COMPLIANCE.—If a State submits a timely State plan amendment under paragraph (1) that the Secretary determines provides for full compliance of the State with the requirements of section 1902(a)(25), the Secretary shall provide for an additional payment to the State of $1,000,000. If a State certifies, to the Secretary's satisfaction, that it is already fully compliant with such requirements, such amount shall be increased to $2,000,000.

''(3) REDUCTION FOR NONCOMPLIANCE.—If a State does not submit such an amendment, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title by 1 percentage point until the State submits such an amendment.

''(4) ONGOING REDUCTION.—If at any time the Secretary determines that a State is not in compliance with section 1902(a)(25), regardless of the status of the State's submission of a State plan amendment under this subsection or previous determinations of compliance such requirements, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of non-compliance as determined by the Secretary.''.

SEC. 604. STRENGTHEN MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) PROTECTING AGAINST THE FRAUDULENT USE OF MEDICARE PROVIDER NUMBERS.—Subject to subsection (c)(2)—

(1) SCREENING NEW PROVIDERS.—As a condition of a provider of services or a supplier, including durable medical equipment suppliers and home health agencies, applying for the first time for a provider number under the Medicare program and before granting billing privileges under such title, the Secretary shall screen the provider or supplier for a criminal background or other financial or operational irregularities

through fingerprinting, licensure checks, site-visits, other database checks.

(2) APPLICATION FEES.—The Secretary shall impose an application charge on such a provider or supplier in order to cover the Secretary's costs in performing the screening required under paragraph (1) and that is revenue neutral to the Federal government.

(3) PROVISIONAL APPROVAL.—During an initial, provisional period (specified by the Secretary) In which such a provider or supplier has been issued such a number, the Secretary shall provide enhanced oversight of the activities of such provider or supplier under the Medicare program, such as through prepayment review and payment limitations.

(4) PENALTIES FOR FALSE STATEMENTS.—In the case of a provider or supplier that makes a false statement in an application for such a number, the Secretary may exclude the provider or supplier from participation under the Medicare program, or may impose a civil money penalty (in the amount described in section 1128A(a)(4) of the Social Security Act), in the same manner as the Secretary may impose such an exclusion or penalty under sections 1128 and 1128A, respectively, of such Act in the case of knowing presentation of a false claim described in section 1128A(a)(1)(A) of such Act.

(5) DISCLOSURE REQUIREMENTS.—With respect to approval of such an application, the Secretary—

(A) shall require applicants to disclose previous affiliation with enrolled entities that have uncollected debt related to the Medicare or Medicaid programs;

(B) may deny approval if the Secretary determines that these affiliations pose undue risk to the Medicare or Medicaid program, subject to an appeals process for the applicant as determined by the Secretary; and

(C) may implement enhanced safeguards (such as surety bonds).

(b) MORATORIA.—The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud a period of delay for any one applicant cannot exceed 30 days unless cause is shown by the Secretary.

(c) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(2) CONDITION.—The provisions of paragraphs (1) and (2) of subsection (a) shall not apply unless and until funds are appropriated to carry out such provisions.

SEC. 605. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) GREATER COORDINATION.—The Secretary of Health and Human Services shall provide for increased coordination between the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'') and its regional offices to ensure that providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program are unable to begin operation and participation in the Medicare program in another State.

(b) IMPROVED INFORMATION SYSTEMS.—

(1) IN GENERAL.—The Secretary shall improve information systems to allow greater integration between databases under the Medicare program so that—

(A) medicare administrative contractors, fiscal intermediaries, and carriers have immediate access to information identifying providers and suppliers excluded from participation in the Medicare and Medicaid program and other Federal health care programs; and

(B) such information can be shared across Federal health care programs and agencies, including between the Departments of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Department of Defense, the Department of Justice, and the Office of Personnel Management.

(c) MEDICARE/MEDICAID ''ONE PI'' DATABASE.—The Secretary shall implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.

(d) AUTHORIZING EXPANDED DATA MATCHING.—Notwithstanding any provision of the Computer Matching and Privacy Protection Act of 1988 to the contrary—

(1) the Secretary and the Inspector General in the Department of Health and Human Services may perform data matching of data from the Medicare program with data from the Medicaid program; and

(2) the Commissioner of Social Security and the Secretary may perform data matching of data of the Social Security Administration with data from the Medicare and Medicaid programs.

(e) CONSOLIDATION OF DATA BASES.—The Secretary shall consolidate and expand into a centralized data base for individuals and entities that have been excluded from Federal health care programs the Healthcare Integrity and Protection Data Bank, the National Practitioner Data Bank, the List of Excluded Individuals/Entities, and a national patient abuse/neglect registry.

(f) COMPREHENSIVE PROVIDER DATABASE.—

(1) ESTABLISHMENT.—The Secretary shall establish a comprehensive database that includes information on providers of services, suppliers, and related entities participating in the Medicare program, the Medicaid program, or both. Such database shall include, information on ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any program.

(2) USE.—Prior to issuing a provider or supplier number for an entity under the Medicare program, the Secretary shall obtain information on the entity from such database to assure the entity qualifies for the issuance of such a number.

(g) COMPREHENSIVE SANCTIONS DATABASE.—The Secretary shall establish a comprehensive sanctions database on sanctions imposed on providers of services, suppliers, and related entities. Such database shall be overseen by the Inspector General of the Department of Health and Human Services and shall be linked to related databases maintained by State licensure boards and by Federal or State law enforcement agencies.

(h) ACCESS TO CLAIMS AND PAYMENT DATABASES.—The Secretary shall ensure that the Inspector General of the Department of Health and Human Services and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

(i) CIVIL MONEY PENALTIES FOR SUBMISSION OF ERRONEOUS INFORMATION.—In the case of a provider of services, supplier, or other entity that submits erroneous information that serves as a basis for payment of any entity under the Medicare or Medicaid program, the Secretary may impose a civil money penalty of not to exceed $50,000 for each such erroneous submission. A civil money penalty under this subsection shall be imposed and collected in the same manner as a civil money penalty under subsection (a) of section 1128A of the Social Security Act is imposed and collected under that section.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

SEC. 701. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an

application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

''(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

''(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) PEDIATRIC STUDIES.—

''(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

''(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

''(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(9) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

''(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

''(1) DEFINITIONS.—For the purposes of this subsection, the term—

''(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

''(B) 'relevant patent' means a patent that—

''(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

''(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

''(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

''(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

''(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

''(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

''(A) the reference product identified in the application; and

''(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

''(4) EXCHANGES CONCERNING PATENTS.—

''(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

''(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

''(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

''(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

''(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

''(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

''(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

''(iv) If the interested third party is issued or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

''(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

''(ii) may specify whether the relevant patent is available for licensing; and

''(iii) shall specify the number and date of expiration of the relevant patent.

''(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

''(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

''(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

''(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product in a treatment indicated in the application, would not infringe the patent; or

''(II) the patent is invalid or unenforceable.

''(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

''(6) NOTIFICATION OF AGREEMENTS.—

''(A) REQUIREMENTS.—

''(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

''(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

''(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

''(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of—

''(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

''(II) the reference product;

''(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

''(iii) excludes any agreement that solely concerns—

''(I) purchase orders for raw material supplies;

''(II) equipment and facility contracts;

''(III) employment or consulting contracts; or

''(IV) packaging and labeling contracts.

''(C) FILING.—

''(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

''(I) 10 business days after the date on which the agreement is executed; and

''(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the

subject of an application described in such subparagraph.

''(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

''(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

''(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

''(E) ENFORCEMENT.—

''(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

''(I) brought by the United States; or

''(II) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

''(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

''(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

''(i) may define the terms used in this paragraph;

''(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

''(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

''(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 702. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting '', including licensure of a biological product under section 351(k) of such Act'' before the period at the end.

SEC. 703. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking ''or'' after ''patent,'';

(2) in subparagraph (B), by adding ''or'' after the comma at the end;

(3) by inserting the following after subparagraph (B):

''(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,''; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: '', or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent''.

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the gentleman from Ohio (Mr. BOEHNER) and a Member opposed each will control 30 minutes.

The Chair recognizes the gentleman from Ohio.

□ 2015

Mr. BOEHNER. Mr. Speaker, all of us know that our health care delivery system needs help. There could be broad bipartisan agreement on the kinds of steps that we need to take in order to lower the cost of health care in America and expand access. The bill before us, in my view, is a big government takeover of our health care system that will replace the current health care that Americans get.

Republicans have offered better solutions all year on the major bills that have come to this floor. I think we had a much better solution on the stimulus bill that would have created twice the jobs at half the cost. I think our better solution on the budget clearly had less spending, less debt and lower deficits.

I think our all-of-the-above American energy plan was a much better solution to the national energy tax, the so-called cap-and-trade bill, that was on this floor in June. I believe that what we have before us, as a Republican substitute, is a commonsense plan that takes steps towards reducing the cost of health insurance in America and expand access. Simple things, like allowing people to buy insurance across State lines, allowing groups of

individuals or small businesses to group together for the purposes of buying health insurance like big businesses and unions can today. How about getting rid of junk lawsuits that drive up the cost of health care in America and the defensive medicine that doctors have to practice as a result.

I think what we have before us and the bill that we are offering is a commonsense approach that does take major steps in the right direction to bring down the cost of health care and to expand access.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I seek to control the time in opposition, and I ask unanimous consent that the time for opposition speakers on the substitute amendment be divided such that the first 10 minutes is controlled by Chairman MILLER of the Committee on Education and Labor; the second 10 minutes is controlled by Chairman RANGEL of the Committee on Ways and Means; and the final 10 minutes is controlled by Chairman WAXMAN of the Committee on Energy and Commerce.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) is recognized to control the time in opposition.

Without objection, that time will be so divided, subject to the Chair's discretion as to the order of recognition.

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, I am here to speak in support of the Affordable Health Care for America Act, one of the most important pieces of legislation this body has considered since the passage of Medicare in 1965 and Social Security in 1935.

Mr. Speaker, every Member of this body has been listening to her or his constituents, and they are saying that they are ready for health insurance reform. They need health insurance reform.

We listened when seniors said they wanted better care from their doctors, and the doughnut hole eliminated. This bill does that. We listened when young adults told us they were having trouble finding insurance and wanted to stay on their parents' insurance until age 27. This bill does that. We listened when the uninsured told us heartbreaking stories about going without needed health care and asked us to give them affordable, quality health care insurance. This bill does that. We listened when the insured told us they were paying too much for insurance and they needed more protections for their health insurance. This bill does that.

Our colleagues on the other side of the aisle have not listened. They are offering a substitute bill that would not accomplish any of the things our constituents have asked for. Instead, they are offering a bill that does not end the discrimination based on preexisting conditions; does not reduce the number of uninsured Americans; does not offer assistance to those struggling to afford health insurance; does not repeal the antitrust exemption for health insurers; and does not stop price gouging by insurance companies. Our bill does all these things and more.

Mr. Speaker, the Affordable Health Care for America Act not only brings quality health care within reach of tens of millions of Americans, it enhances the care that those with insurance and Medicare already receive. This bill is as much about the insured as it is about the uninsured. It is a monumental bill. I urge defeat of the Republican substitute and, indeed, encourage passage of H.R. 3962.

The SPEAKER pro tempore. Without objection, the gentleman from Michigan will control the time on the proponent's side.

There was no objection.

Mr. CAMP. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the American people deserve and demand a commonsense approach to health care reform that, one, makes health care more affordable; two, that guarantees all Americans, regardless of preexisting condition, have access to affordable health care; and, three, does so without raising taxes, without increasing the deficit and without the Federal Government making health care decisions that should be made by patients and doctors.

The Common Sense Health Care Reform and Affordability Act, the House Republican health care bill, does that. The plan offered today by the Speaker does not.

Just some of the highlights of the Republicans' Common Sense Health Care Reform and Affordability Act include:

Lowering health care premiums: The Republican plan will lower health care premiums for American families and small businesses, addressing Americans' number-one priority for health care reform.

According to the Congressional Budget Office, the Republican health care reforms would reduce premiums by up to 3 percent for Americans who get insurance through a large business, up to 8 percent for Americans without employer-sponsored insurance, and up to 10 percent for those working for a small business. CBO has not made a claim that the Democrats' bill would lower premiums at all.

What do these numbers mean? It means families who do not have health insurance in 2016 through their job could buy health insurance that is $5,000 less expensive than the cheapest plan the Democrats offer.

The Republican plan guarantees access to affordable health care for those with preexisting conditions. Republicans create universal access programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of preexisting conditions or past illnesses, have access to affordable care, while lowering costs for all Americans.

The Republican plan reduces the number of junk lawsuits, which saves taxpayers' money and lowers premiums, by enacting medical liability reforms modeled after the successful State laws of California and Texas.

The Republican plan prevents insurers from wrongly canceling a policy unless a person commits fraud.

The Republican plan encourages Small Business Health Plans so these employers can pool together and offer health care at lower prices, just as large corporations and labor unions do today.

The Republican plan encourages innovative programs by rewarding States that reduce premiums and the number of uninsured. In comparison, the Democrat bill adds a new unfunded mandate States cannot afford with their over $400 billion expansion of Medicaid.

The Republican plan allows Americans to buy insurance across State lines and find the health care plan that best meets their needs at a cost they can afford.

The Republican plan promotes prevention and wellness by more than doubling the financial incentives employers may reward employees who adopt healthier lifestyles.

Republicans enhance health savings accounts by allowing Americans to use HSA funds to pay premiums for high deductible health insurance.

And the Republican plan allows dependents to remain on their parents' policies up to the age of 25.

The health insurance reforms in the Republican bill will significantly reduce health care premiums, insure millions of Americans, guarantee those with preexisting conditions have access to quality, affordable care.

We do all of this without raising taxes, without spending $1 trillion we don't have, without cutting Medicare and without putting some new health czar in between doctors and patients, which is what the Democrat majority does in their government takeover bill.

Clearly the bill offered by the Speaker is not what the American people want. Americans are clamoring for lower cost health care and that is what the Republican plan offers.

I urge my colleagues to reject the Democrats' government takeover of health care and vote ''yes'' on the Republican substitute that will lower health care premiums.

I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members not to traffic the well when another Member is under recognition.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2½ minutes to the gentleman from Massachusetts (Mr. TIERNEY), a member of the committee.

Mr. TIERNEY. I thank the gentleman.

Since 1995, when our Republican colleagues held the majority in the House of Representatives, until 2007 when they relinquished that and the voters threw them out, they had done exactly nothing, nothing, with respect to the health care crisis in this country.

Now they want to come in and they want to do something. They want to have you pay less for getting less. This is their great plan.

The one thing they tried to do in 2003 would put pharmaceutical prescription drugs in Medicare which they did by giving seniors a so-called doughnut hole they had to pay for and costing us $600 billion on our current debt.

My friends, the only ones they made happy then were the pharmaceutical companies, and the only ones they want to make happy now are the private insurance companies. They want to try to kill reform. If they can't kill reform, they want to give them this gift of a Republican substitute.

While they sat idle since 1995, family health insurance policies rose from 7 percent of median income to 17 percent. Sixty percent of families reporting bankruptcies did so in part because of health care costs. Forty-six million Americans went uninsured, 85 percent of those in working families.

Small business premiums went up 129 percent. Twenty-eight million of our uninsured are small business owners, employees or their families. Small businesses are projected to lose $52.1 billion going forward in the next decade if we continue on the Republican path of do nothing.

The question is, who is on our side? Who is on the side of the consumers, the individuals, the small businesses and the families, and that is the bill that the Democrats have put forward on this floor. It is affordable; it is health care for every American.

If you compare the two bills, you will see the Congressional Budget Office says the Republicans may—may—save you from 0 to 3 percent on 80 percent of the private premiums.

The Democratic bill saves you 12 percent. The Democratic bill covers 96 percent of Americans. The Republicans in 2019 will leave you exactly where you are today, covering only 83 percent of the people, leaving by that time 52 million uninsured.

We will end the discrimination against people with preexisting conditions. They will study it.

We will have an exchange for small businesses and employees so they get better prices comparable to what large companies have now been able to get. They will do nothing of the kind except let you shop for a place, but to get your insurance it might cost you less because you get less, because you will have a race to the bottom, where insurance companies will be able to avoid consumer protections of States and practice fraud almost indiscriminately. There will be no way of cutting it back. You pay less because you get less.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

When Republicans were in the majority, we passed a children's health initiative; a prescription drug plan for seniors; we put wellness into Medicare; we established portability so people could change jobs and keep their health care; and we established health savings accounts. Our record on health care is strong. What we need is this continuation of this step-by-step approach to comprehensive health care reform.

I would now yield 5 minutes to the distinguished gentleman from Indiana (Mr. PENCE).

(Mr. PENCE asked and was given permission to revise and extend his remarks.)

Mr. PENCE. Mr. Speaker, I rise in support of the Republican substitute.

After months of overwhelming public opposition to a government takeover of health care, liberal Democrats here in Washington are choosing to ignore the clear voice of the American people, bringing forth a freight train of runaway Federal spending, bloated bureaucracy, mandates and higher taxes.

And even a few courageous Democrats have been willing to speak out. In opposing the bill, the distinguished Democrat chairman of the Armed Services Committee, IKE SKELTON, a man who knew President Truman, said that he, quote, had serious concerns for Missourians who have private insurance plans they like.

And my Democrat colleague, DAN BOREN of Oklahoma, said, and I quote, the worst thing we could do in a recession is raise taxes, and this bill does just that.

□ 2030

As these Democrat colleagues attest, if the Pelosi health care bill passes today, you probably will lose your health insurance, and you might just lose your job. The Pelosi health care plan targets us when we are most vulnerable. Illness, our own, or, more importantly, the illness of a parent, spouse or a child, has the capacity to suspend our priorities. What was important before the crisis grows dim in the harsh light of disease affecting a loved one. The result, little by little, in the midst of a family crisis we yield our freedoms and our resources to the ever-growing appetite of the Federal Government.

But if liberal Democrats think this is what our Nation wants, they don't know the America that I know.

Mike Schwaller is my cousin. He is an extraordinary young man. He has been struggling with cancer, but throughout has maintained his faith in Christ and his courage. He has been an inspiration to us all.

Mike wrote me an email the other day, and he gave me permission to share it. As a cancer patient with limited treatment options, he is awaiting insurance approval for experimental treatment. He seems like just the kind of American that my Democrat colleagues keep telling us want government-run insurance. But they don't know Mike.

As he wrote about his coverage recently, he said, If this was a government bureaucracy, I have no faith that it would be processed in a timely manner, and even then, if it would be approved. The idea of a public health care option, he wrote, as a chronic cancer patient scares the living hell out of me. I feel that at this moment in time you are fighting for me, and my life. Please, please, don't give up or give in.

Michael, we won't.

The truth is, this debate is not just about health care. It is about who we are as a nation. As President Reagan said, it is about ''whether we abandon the American revolution and confess that a little intellectual elite in a far distant capital can plan our lives better for us than we can plan them for ourselves.''

You know, earlier today I greeted about 50 Hoosiers, mostly in wheelchairs, unit caps and uniforms, down at the World War II Memorial. These heroes were gathered for their first and maybe their only visit to that monument built in their honor.

As I made my way back to the Capitol, I thought about those brave men and what sustained them in those days where the survival of democracy hung in the balance. I believe it must have been because they were fighting for a cause more important than their health or even their lives, and that cause was freedom.

In the coming hours, we are going to take a vote of incalculable significance to the American people, and we will see what our so-called Blue Dog Democrat colleagues are made of. We will see whether Democrats who profess to believe in limited government will take a stand, or whether they will fold under the weight of the Democratic majority in the White House.

Look, I know from personal experience, it is no easy thing to take on your President or your party on a major piece of legislation. But let me assure my colleagues, decent Americans all, if you will take this stand for freedom, for the right to live and work and care for a family without the unnecessary intrusion of the government, I believe with all my heart that you will know for the rest of your lives just what those men in wheelchairs have known every day since they came home, that when freedom hung in the balance, you did freedom's work, and the American people will never forget it.

Mr. GEORGE MILLER of California. I yield 1½ minutes to the gentleman from Virginia (Mr. SCOTT), a member of the committee.

(Mr. SCOTT of Virginia asked and was given permission to revise and extend his remarks.)

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the freedom to be uninsured. Seniors in my

district do not want us to repeal government-run Medicare so that they can enjoy a freedom to be uninsured, and those without insurance now do not view themselves as enjoying some freedom. They want insurance.

The Republican substitute responds to the comprehensive Affordable Healthcare for America Act with a bill that fails to reduce costs, fails to cover uninsured Americans, and it may study, but it does not help, those with preexisting conditions. It does, however, attack innocent victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs, and yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of malpractice. For those victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts the cost of medical malpractice from the doctor to the victim's own private insurance, and, in some cases, causes the injured victims to lose the right to sue before they even know they have been injured.

None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now.

The substitute should be defeated.

Mr. CAMP. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Michigan (Mr. MCCOTTER).

Mr. MCCOTTER. I thank the gentleman.

Mr. Speaker, as the health redistribution bill before us attempts to put its skid marks on history, it further proves Democrats are the party of the past. Their antiquated government-run takeover of Americans' health care is as ill-suited to our times as a leeching is to laser surgery.

We do not live on a government-run globe. We live in a people-powered world, one belatedly awakening to America's revolutionary experiment in human freedom and self-government. Today, from the palms of our hands, we can traverse distant strands of Earth to access friends and goods. Why in the world would we put in the palm of a bureaucrat's hand our health care?

Yet, this is precisely what the hoary voices of hidebound ideologues demand; namely, that our generation's innovation revolution and its unprecedented expansion of human empowerment be buried beneath big government.

They are gravely mistaken. Amidst our constantly changing and challenging times during this age of globalization, our generation's innovation revolution is burying big government in the ash bin of history.

Thus, the public and Republicans oppose the Democrat's fossilized model of a mammoth government-run takeover of Americans' health care. Instead, we embrace and harness our generation's innovation revolution to empower Americans as citizens and consumers and advance patient-centered wellness.

Our plan will increase the supply of health care to meet rising demand and reduce costs through such sensible, affordable, and helpful reforms as ending exclusions for preexisting conditions, reforming medical liability laws, expanding Health Savings Accounts, allowing small businesses to band together to provide coverage for employees, permitting health insurance sales across State lines, and incentivizing preventative health care and wellness.

All this can be achieved without trillions of dollars in new spending, taxes, deficit and debt, and without big government controlling your health care decisions.

Trapped in the past, there are those who ignore behind closed doors the opportunities of our age. If Democrats impose their government-run takeover of health care on the American people, the consequences will be higher costs, lower quality, fewer choices, and lost jobs during this painful recession.

But for those with an abiding faith in our free Republic's people and their future, there is a better way—maximizing America's innovation revolution to advance patient-centered wellness in our people-powered world.

Pray we do.

Mr. GEORGE MILLER of California. I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS), a member of the committee.

Mr. ANDREWS. Mr. Speaker, when you can't win an argument on the facts, you resort to emotion. The minority can't win the argument with insured people because they preserve the right of insurance companies to discriminate on the basis of preexisting conditions.

They can't win the argument with senior citizens because they ignore the doughnut hole that they created in 2003 in the Medicare part D.

And they don't ignore the uninsured. I will give them some credit for that. There are going to be 50 million uninsured in 2010. They do change that. Their plan would make it 55 million uninsured 10 years from now.

So they are standing on a motion, and we hear a Member say this: ''We cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer.''

But the Member wasn't a current Member, and the time wasn't now, and the issue wasn't this bill. The Member was Durward Hall, the time was 1965, and the issue was Medicare.

They were wrong then, they are wrong now, and their substitute is wrong. You should vote no.

Mr. GEORGE MILLER of California. I yield myself 2 minutes.

Mr. Speaker, if the Republicans' health care plan was a plan for a fire department, they would rush into a burning building, and they would rush out and leave everybody behind. If their plan was an evacuation plan, it would be like Katrina. When they got all done evacuating people, they left them all behind.

They say their plan is inexpensive. They say their plan saves somebody money. But 10 years from now there are as many uninsured as there are now.

At the end of their watch, after 12 years of control of this Congress, 8 years of control of the White House at the same time, they left behind 37 million Americans without health insurance. That is what they left behind on their watch. Now they come forth with a plan for the future, and over the next decade they are going to leave behind 50 million Americans.

Want to buy it? Want to try it? Want to sell it? Come on, America. Buy this one. You are guaranteed to be left behind if you are left behind today.

What a plan. Ha. God save us.

Mr. CAMP. At this time I yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the ranking member of the Energy and Commerce Committee.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, I asked to go after the distinguished chairman of the Education and Labor Committee because what we have here is a failure to communicate, or perhaps a difference in philosophy.

The Democrats have decided that the bottom line is coverage. By golly, coverage no matter what. Whether you want to be covered or not, you are going to be. We are going to have an employer mandate. We are going to have an employee mandate and an individual mandate. We are going to have a premium mandate.

We are going to have how you cover the insurance, a ''comparative research council,'' to dictate the practice of medicine. We are going to raise Medicaid to 150 percent of poverty, and automatically enroll every individual in this country who is unmarried, whether they want to be or not.

We are going to tell every young American who has decided that they don't want to pay those premiums, they want to save up to get married or to buy a home, that, by golly, they are going to have to take insurance, and they are going to pay three to four times what they would under the current system because there is only a two-to-one ratio. So they are going to get their coverage, at a cost of $1.2 trillion.

Now, we have a different philosophy. We think you need to control costs, but we also agree that you have to provide access to the private insurance market if you can't get it today and you want it.

Congressman MILLER talks about the 40 to 50 million Americans that are not insured, and he is right. But of those 40 to 50 million, 15 to 20 million are in this country illegally. Ten or 15 million are young Americans who don't want insurance.

When you really boil it down, there are 5 to 10 million Americans who have a preexisting condition or work where insurance is not provided and they can't afford it.

□ 2045

Our plan covers them. It gives them the opportunity. That doesn't give them the money, but it gives them the opportunity. So we have a difference in a philosophy.

We don't believe in mandates and make no apology about it, but we do believe in the individual opportunity. We believe in individual choice. We believe in the American system of free enterprise. We believe in lowered taxes, and we believe in a plan that's going to lower premiums an average of $5,000 per person per year for the next 10 years. That's what CBO says. That's not me. That's the CBO.

So there is a choice. Bigger government, more mandates, more control, less freedom, or lower costs, more opportunity, more freedom, more choice. I vote for more freedom.

Vote ''no'' on the Big Government plan. Vote ''yes'' on the individual opportunity plan.

Mr. RANGEL. At this time, I yield 1 minute to the gentleman from California (Mr. STARK), the chairman of the Ways and Means Subcommittee on Health.

I would like to take this time to thank him for the great work he's done over the years, not just for our committee, but for this Congress, and I would like to thank him publicly.

Mr. STARK. I thank the chairman for yielding.

Mr. Speaker, the Republican substitute is not a substitute on health reform. It substitutes gifts to the wealthy insurance companies for morality and dignity. Their bill spends $61 billion over the next decade, and what would the American public get for that investment? It would get 5 million more uninsured people than we have in America today. That's not a conservative solution. It's no solution at all.

Our legislation expands coverage to 36 million more Americans, reforms the insurance market to end abusive practices, provides financial assistance to lower-income and middle-income families, creates a public health insurance option that will make health insurance companies compete on quality, provides security for our seniors, and protects our children's futures by not adding one dime to the deficit.

A vote for the Republican substitute is nothing more than a vote for transferring money to wealthy insurance companies. Vote ''no'' on the Republican substitute and ''yes'' to provide affordable, quality health care for all Americans.

Mr. CAMP. At this time, I yield 1 minute to the gentleman from South Carolina (Mr. BROWN).

Mr. BROWN of South Carolina. Mr. Speaker, I rise in strong support of the Republican amendment and true health care reform. Our plan makes the cost-saving changes so sorely needed in our health care system without forcing our children and grandchildren into unending debt.

This amendment will allow insurance to be bought across State lines to drive down costs and allow small businesses to band together in order to negotiate fair and affordable coverage. Furthermore, this amendment improves quality, putting you and your doctor in charge of your care by removing the powers of insurance companies and trial lawyers.

Finally, this amendment ensures that the taxpayer dollars my constituents in South Carolina's First Congressional District pay into the Federal Treasury never find their way into abortion clinics.

Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote ''no'' on final passage.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington, Dr. MCDERMOTT, who worked his whole career down here to improve the quality of health care for all Americans.

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, the Republican health plan and proposal has been in effect since 1995. A friend of mine came to New York, had some problems, got on the phone to call a doctor, and the first question that is always asked is what kind of insurance do you have. When he said he didn't have any, they said, Well, we can't take care of you unless you come to the office with $250 in cash. We'll see you if you do that. He said, I don't have that kind of money. They said, Then go to the emergency room. That's where 50 million people in this country are today. Go to the emergency room if you can't come with the cash to hand it to the doctor.

My office phone today has been ringing off the hook with people demanding that we have health care now. The Republican alternative doesn't help anyone, except protects the insurance companies. The bankruptcy of this plan is pretty clear to everybody. Health analysts, the media, The New York Times, the CBO all agree that the Republican plan would leave 42 million people with nothing.

Now, the Republican plan does nothing to help the seniors. It really isn't a plan. It's just a bunch of stuff they scraped up off the floor that they had laying around for 12 years and did nothing.

Now, why don't they put forward a plan? Well, I will tell you. I've cracked the code. This plan they brought out here, they either haven't read their own bill—because you couldn't keep a straight face and come out here and say it was a plan—or they would rather spend more time hating government than helping people. Remember what they did in New Orleans. That's what their attitude about government is. Don't make it work for the people. Just let people understand, You're on your own, folks. That's our plan. We believe in freedom; you're free to be on your own. But most people can't take care of their health care problems on their own. They're lucky if they can.

Vote against this proposal, and vote for the bill.

The phones in my office have been ringing off the hook because my constituents want secure quality affordable healthcare now. Meanwhile the Republicans have put forward an alternative that doesn't help anyone but protect insurance companies.

The bankruptcy of the Republican plan is not just my opinion—analysts, the media, and the Congressional Budget Office all agree the Republican plan will leave 42 million out in the cold. The Republican plan does nothing to help people with pre-existing conditions or to help seniors. The Republican plan is no plan.

How could they have put forward a plan that doesn't solve any of the healthcare problems Americans face? Well, I may have cracked the code. Either they haven't read their own bill or they'd rather spend more time hating government than helping people.

The Republican approach is just a continuation of the status quo while the Democratic plan covers 96% of Americans. My constituents have demanded action. The time is now.

Mr. RANGEL. No one has worked harder on this bill than Congressman Lloyd Doggett from Texas, and it's my honor to now yield 2 minutes to the gentleman.

Mr. DOGGETT. To help cover huge medical bills in Bastrop, Texas, they held a Main Street pancake supper, an auction at the American Legion. Well, essential health care shouldn't depend on the kindness of strangers or the goodness of neighbors and certainly not on the ''just say no'' of the Republican Party or the weak TEA parties brewed up by the insurance lobby.

Now, belatedly, they offer a scheme as skimpy as a hospital gown. They do nothing to help seniors. Their proposal is inefficient, it's ineffective, and it's wasteful. Masquerading as reform, their bill authorizes insurers to continue denying coverage for preexisting health conditions, such as acne or a C-section. Republican obstructionism has itself become one giant preexisting condition to meaningful change.

This is a typical old-time Republican medicine show. Do a little bit for 5 percent of the people. Do nothing for the other 95 percent of the uninsured, and leave the portion of American families who are uninsured the same tomorrow as today. The only thing they propose more of is more insurance policy loopholes.

Freedom. They want the freedom to go broke after a medical emergency, the freedom to have more bankruptcies, medical bills—the number one cause of personal bankruptcy in America today. We cannot secure bipartisan support for health insurance reform tonight because they don't support any real solutions for the uninsured.

Our Democratic plan is a lifesaver for 12 times as many Americans, and it's a dollar saver, responsibly reducing the national debt by $36 billion more than this phony Republican scheme.

Now is the time for a truly historic choice. The Republicans have chosen to side again with the big insurance monopolies. We choose to strengthen Medicare. We chose to stand up for the millions of struggling families who have been denied health care access for too long.

Mr. RANGEL. Could I ask how much time I have remaining, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from New York has 5 minutes remaining.

Mr. RANGEL. I yield 2 minutes of that time to the gentleman from Oregon (Mr. BLUMENAUER) and ask him to share the great contribution he has made and the loopholes we find in the Republican substitute.

Mr. BLUMENAUER. I appreciate the gentleman's courtesy.

I hope every American examines the plan that has been offered to us by the Republicans.

Our citizens are outraged by practices of taking away insurance when you need it or denying coverage for preexisting conditions. Our bill fixes it. You won't find it in the Republican bill. Republicans strip out provisions so important to Oregon and other low-cost, high-quality States. Republicans do not deal with those vast regional disparities.

They ignore the extra costs faced by seniors caught in the prescription drug doughnut hole while Democrats provide financial relief within the next 2 months. If Republicans have their way, there will be more uninsured Americans in 10 years than there are today. Weaker protections ignore the needs of the most vulnerable, yet the CBO says the Republican plan will increase the deficit by $36 billion more than the Democratic plan.

Mr. Speaker, this is a colossal failure of imagination. The Republicans could have passed this package any time during the 6 years they and George Bush ran everything. They didn't bother because it wasn't worth it.

Last March, Republican Minority Leader BOEHNER famously said that his Members shouldn't legislate. With this package as the best they could do, the Republicans have met the challenge not to legislate.

Mr. CAMP. Mr. Speaker, at this time, I yield 3 minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Speaker, I thank the gentleman for yielding.

The Republican Congresses did send important parts of this plan, the House, to the other body. We sent lawsuit abuse reform seven times. We sent associated health plans at least a half dozen times. They didn't get to the floor. We continue to send the elements of this plan that save every taxpayer money and also save every insured American money. This is the only plan that reduces the cost of insurance for every group of insured Americans.

One of the goals that the President set for health care reform was to reduce the cost of premiums. This is the only plan that does that. It does it for individuals. It does it for small businesses. It does it for large groups.

This is a plan where we could provide access to coverage for everyone regardless of preexisting conditions. Now, we don't spend $1.3 trillion to do that. We spend about $23 billion to make the risk pools work better and ensure access for everybody. We're for access for everybody to coverage; we're just not for spending $1 trillion to create that access.

This plan lowers premiums. It prohibits insurance companies from canceling policies. It prohibits insurance companies from capping the lifetime expenditures that those policies might incur.

One of the reasons that there were more people uninsured at the end of the 10 years under this plan is, when our friends on the other side insisted on the children's health insurance plan, they put everybody that goes on that plan in the first 5 years back into no insurance in the last 5 years. Look at the numbers. That's where those numbers go up. You could pretend that our plan puts the numbers up. We're not the one that said we're going to insure all children for 5 years and in the second 5 years they're back to where they are today. Check the numbers. Look at what this does for premiums. Look at what this does for families. Look at what this does for individuals.

This is a plan that truly does keep what works and fixes what's broken. The President repeatedly has said, Everyone, if you like what you have, you should be able to keep it. This is the only plan that would allow that pledge to be made and be kept.

Mr. Speaker, I encourage my colleagues to support this plan. Let's take these first steps that work without bankrupting the American people. I urge support of this plan.

The SPEAKER pro tempore. The gentleman from New York has 3½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin, RON KIND, and thank him for the great contributions he has made to looking at health care the way it should be, and that is value and not volume.

(Mr. KIND asked and was given permission to revise and extend his remarks.)

□ 2100

Mr. KIND. Mr. Speaker, let's be clear. We really face three choices here tonight: our plan, their plan, and the consequences of doing nothing.

But we know what inaction will bring already. We will pay more, we will get less, and we will bankrupt ourselves as a Nation due to rising health care costs. So let's just take a moment and compare the two plans before us this evening.

According to the Congressional Budget Office, not only is our health care reform plan completely paid for, but we reduce the national deficit by $109 billion in the first 10 years alone; they by only $68 billion. We cover an additional 36 million uninsured Americans in this country; they increase the number of uninsured from 47 million today to over 52 million by 2019. We cover 96 percent of Americans under our plan; they, 83 percent. We give small businesses tax credits to use in the national exchange to make it more affordable for them; they do nothing. We ban the discrimination based on preexisting conditions; they do nothing. We close the doughnut hole for seniors in Medicare; they do nothing.

But, most importantly, they do nothing to reform how health care is delivered and how we pay for it in this country. We change the fee-for-service payment under Medicare, which is all volume based, to a reimbursement system that rewards quality and the value of care. Why is this important? Because studies show that we are spending over $800 billion every year on tests and procedures that don't work. They don't improve patient care, and because of overtreatment in too many instances, we're making patients worse off rather than better off.

Our payment reform plan has the best potential of increasing the quality of care for all Americans at a substantially lower price. They do nothing.

Mr. Speaker, just 2 months ago President Obama stood in this Chamber and reminded us what the true character of the American spirit is all about. He reminded us that we did not come here to fear our future, but to shape it. That is the historic opportunity that we have before us this evening.

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

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

Mr. KIND. I thank the gentleman.

I ask my colleagues to support true reform and provide all Americans with access to affordable and quality care that they all deserve.

Mr. RANGEL. Mr. Speaker, I yield myself the balance of my time.

I'm not going to be as difficult with the Republicans as some of my colleagues because I'm glad at the end of the day they finally understood the problem. And even though it was only Tuesday that they actually put something together for us to look at, at least we know that some of them are going in the right direction.

It's going to be tragic to explain this to the American people not only now but in the future as to when they had a great opportunity. They lost it on Social Security. They said government would become too big. They lost it on Medicaid. They said that would be too much for the poor folks, that they should have freedom instead of health care. And they certainly lost it in

Medicare where they made it appear as though it was going to be a Big Government takeover.

And now it just seems to me that they've proven how well government can do in these programs. And the fact that in lieu of just plain freedom, in lieu of telling people that they can get insurance if they're at risk, the whole idea that they're proud of people who cannot afford to do this at least to have the opportunity to do it.

So, Mr. Speaker, I just hope that some of those on the other side might allow morality to go beyond just party loyalty.

At this time it gives me pleasure to present to this body Chairman WAXMAN, who has done so much to make this a reality.

Mr. CAMP. Mr. Speaker, I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I'm pleased to yield 1 minute to the gentleman from Vermont (Mr. WELCH).

Mr. WELCH. Mr. Speaker, tonight the question before Congress is neither new nor complicated: Will we do what it takes to make health care affordable and available to all Americans?

Our predecessors in Congress faced similar choices when they extended voting rights to all Americans, established Social Security and Medicare for all seniors. Mr. Speaker, Congress faced those challenges and we are the better for it. We did so not without conflict and controversy but with some bipartisan support.

Tonight is different, unique. Our Republican friends have assured us that not a single member of their caucus will vote for health care reform. Every single person will vote ''no.''

The Republicans' alternative says to Americans with a preexisting condition, you are on your own. To the 47 million Americans without insurance, you're on your own. To the millions of Americans who can't afford the coverage that they have, you're on your own.

Our health care bill has a different philosophy, the one that prevailed when Democrats, and some Republicans, passed Social Security, voting rights, and Medicare: We are in it together.

Mr. WAXMAN. Mr. Speaker, I'm pleased to yield 2 minutes to a very distinguished member of our committee, the chairman of the Energy Subcommittee, previously chairman of the Telecommunications Subcommittee, and a very highly respected Member of this body, the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY of Massachusetts. The Republican plan is really quite simple: you're on your own.

The Republican plan tells Americans if you get sick and you don't have insurance, you're on your own. The Republican plan tells Americans if you are denied coverage because of a preexisting condition, you're on your own.

The Republican leaders in Washington seem to be suffering from their own preexisting condition: a heart of stone. If you kicked them in the heart, you would break your toe.

They say that the Democratic plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill and not the Republican bill. The Republicans claim the Democratic bill will hurt seniors, but AARP has endorsed the Democratic bill and not the Republican bill. Why does AARP support the Democratic bill? Because the Democratic bill will close the Medicare part D doughnut hole for seniors. The Republican bill does not. We provide support for low-income seniors; they do not. We will extend the solvency of Medicare; they do not. Right now 60 percent of all bankruptcies in America are because of medical expenses. The Democratic bill makes sure that never happens again; the Republican bill does not.

You know, the GOP used to stand for Grand Old Party. Now it stands for ''grandstand, oppose, and pretend.'' They grandstand with phony claims about nonexistent death panels. They oppose any real reform. And with this substitute they pretend to offer a solution while really doing nothing. GOP: grandstand, oppose, and pretend.

And make no mistake about it, the Republican substitute is not real reform. It does nothing to curb skyrocketing health care costs. It does nothing to provide real insurance coverage to millions who are now uninsured. It does nothing to stop the unfair practices of insurance companies.

I urge my colleagues to vote ''no'' on the Republican ''do-nothing'' substitute.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. MICA).

Mr. MICA. Mr. Speaker, this is a sad day for the Congress and particularly a sad day for Americans who lack health care coverage. While Democrat efforts to resolve health care problems may be well intended, in fact they totally miss the mark. People want lower premiums, increased access, less cost, and less red tape. They want choice and quality health care.

Instead, the Democrat health care plan dramatically expands government, cuts Medicare, and imposes significant costs to taxpayers. The creation of 118 new Federal programs, agencies, and czars adds bureaucracy and red tape rather than providing a cure to bring health care costs down and accessibility up. The $729 billion in new taxes on Americans and small businesses will result in a loss of 5.5 million more jobs at a time when our country can least afford it and unemployment has topped a record 10.2 percent.

I oppose the cuts of nearly a half trillion dollars in Medicare. This is the wrong solution at the wrong time.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 1 minute to the gentleman from Texas (Mr. GONZALEZ).

Mr. GONZALEZ. Mr. Speaker, I rise in strong opposition to the substitute.

This substitute includes medical liability reforms that draw on the Texas model. I'm from Texas. Let me tell you about the Texas experience.

We were promised that medical malpractice reform in Texas would result in attracting doctors to underserved areas. Today, Texas ranks 43rd out of the 50 States in the number of doctors per capita.

We were promised that it would rein in health costs. Health care costs in Texas with Medicare alone rose 24 percent in the 3 years after Texas tort reform.

We were told that it would reduce the cost of health care insurance for Texans. Premiums actually increased 86.8 percent from the years 2000 to 2007. The average insurance policy for a family in Texas went from $6,638 to $12,403.

We were told that it would make health insurance plans more readily available for Texans. Today, Texas has the highest rate of uninsured adults and the highest rate of uninsured children.

If ever there was a time not to mess with Texas, it is tonight. Vote ''no'' on the substitute.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 2 minutes to the gentleman from New York (Mr. WEINER), an important member of our committee and a leader in health care reform.

Mr. WEINER. You know, there are honorable people on both sides of this debate; but there are moments that come along, and they come along about every generation or so, that make it clear why this side of the aisle are Republicans and why we're Democrats.

In 1935 when there was the Social Security Act and we decided we weren't going to allow 30 percent of seniors to slip into poverty, Democrats proposed, Democrats passed; Republicans opposed Social Security.

In 1965 when Medicare was passed, Democrats proposed, Democrats supported; Republicans opposed, and now Medicare is a fact of life. And the very same arguments that were made against Medicare then are being made tonight.

I hear this talk about the single-payer plan that's going to creep over. I can tell you I wanted a single-payer plan. I would like it to be there, but it's not. But you opposed it then, and now you claim to support it.

There's been a lot of talk about how big the bill is, but here's what it's all about: this is what Members of Congress get. This is a guidebook with affordable health care plans, many choices, deep discounts because we pool people together, minimum standards for each plan. This is what Members of Congress get, but they don't want you, the American people, to get it.

This is what it's about: they say they want to protect Medicare, but it was

they who wanted to eliminate it. They say they want to protect Social Security. It was they who wanted to privatize it. Now they say we don't want to cover those who are uninsured because you shouldn't care.

Well, I say to my colleagues, who pay those bills? The bill fairy? Who pays those bills are you, the taxpayer. They say they want you to pay those, too.

When you look at how big the bills are, remember this document. Eight million Americans who work for the Federal Government, including my colleagues, get this document in the mail. They get good health care. We want it for you. They're going to get Medicare at 65. They don't say we don't want Medicare because we don't believe in single-payer. They want it because they want to take and take and take, but they don't want it for you.

The Democrats want this for you and the Republican Party just wants it for themselves.

□ 2115

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members to address their remarks to the Chair.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

As a Senator from Maine who voted for the Senate finance bill remarked on the House legislation pending said, I do not know what world they live in, but all I know is it is totally detached from the average person, the average business owner who is struggling to keep their doors open, and to have that level of taxation is breathtaking in its dimension. I just think it is so out of proportion with reality, with Main Street, America, that it is hard to believe, frankly.

I now yield 5 minutes to a distinguished member of the Ways and Means Committee, the distinguished minority whip from Virginia (Mr. CANTOR).

Mr. CANTOR. Mr. Speaker, today brings the culmination of an extensive and spirited debate over health care reform. Both parties agree that the status quo is unacceptable. Obviously, we disagree on how to fix what is broken. And as the gentleman from New York just said, there are times in this body when we really can tell the difference between us Republicans and you Democrats, and this is certainly one of them.

Mr. Speaker, the Democrat solution is a 1,990-page, trillion-dollar overhaul of the health care system we know, a sweeping new entitlement that raises taxes, cuts benefits to seniors and, Mr. Speaker, it spends over a trillion dollars that we don't have.

Republicans believe there is a better way. We have proposed an alternative approach that offers a stark contrast to the majority's plan. It is a fiscally responsible and reasoned approach.

The majority's proposal overturns the whole system. We keep what works and then try to fix what is wrong.

Their bill puts the government between families and their doctors. Ours doesn't.

Their plan cuts Medicare benefits to seniors. Ours retains them.

Their proposal blows a hole in the deficit. Ours actually saves money.

Their bill imposes penalties and mandates on our small businesses that cost jobs. Ours does not.

Specifically, Mr. Speaker, our bill will help you access health care if you lose or change your job. And it will ensure that you have access to medical care if you have a preexisting condition. And we also, Mr. Speaker, deliver on something that the majority refuses to even talk about, and that's real, meaningful medical liability reform.

And most importantly, Mr. Speaker, we produce cost savings for workers, families, and small businesses. The Congressional Budget Office says that the Democrats' new government-run system won't reduce costs. CBO says our legislation lowers health care costs. In fact, CBO says that the Republican plan cuts premiums by up to 10 percent for employees covered by small businesses, up to 8 percent for those not covered by employers, and up to 3 percent for employees covered by large businesses.

Mr. Speaker, in the face of 10.2 percent unemployment, Americans want jobs. They want less government spending and more economic security. The majority's bill shows they have not listened. Ours shows we have.

Interestingly, Mr. Speaker, the only bipartisanship on Capitol Hill today will be in opposition to Speaker PELOSI's trillion-dollar-plus government overhaul of America's health care system.

With that, Mr. Speaker, I urge passage of this substitute.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that the 2 minutes that has been reserved for the Education and Labor Committee debate time in opposition to the Republican substitute be transferred to the Energy and Commerce Committee's time.

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

There was no objection.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding and for the extraordinary work that he and others have done on this bill.

The extraordinary diversity of our Democratic Caucus, Mr. Speaker, from right to left, has ensured that this bill represents a cross-section of our country, urban, suburban and rural. The incredible diversity of our Democratic Caucus, representing Republicans, right-leaning, moderate, and progressive areas meant that we could not come to this floor today without a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured.

Thus, there can be no doubt this evening that the Affordable Health Care for America Act is a balanced bill and the best bill for the citizens of the United States of America.

The extraordinary diversity of our Democratic Caucus—from right to left has ensured that this bill represents a cross-section of the our country—urban, suburban, and rural. The incredible diversity of our Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could come to this floor today only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates, who believe that only Medicare for all can markedly reduce costs while providing adequate health care to the middle class and the uninsured. Thus, there can be no doubt that the Affordable Health Care for America Act is the best bill for the citizens of the United States of America.

The bill's greatest achievements are that it would reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; would end discrimination by insurers who dropped or refused to renew or sell coverage because of health status and would ensure that coverage is affordable by providing subsidies for people in employer-based health care or through an insurance exchange of private insurers and a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

PARLIAMENTARY INQUIRY

Mr. GOHMERT. Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. GOHMERT. Mr. Speaker, my understanding of the rules is that there is required to be a copy of the bill, and since we have a manager's amendment, that is supposed to be somewhere. A number of us have been trying to find a copy of the manager's amendment since we are going to be voting on it. I hear some aahs, but isn't there supposed to be a copy, and if so, where would that copy be, since we are about to do this to the American people?

The SPEAKER pro tempore. The official papers are at the desk.

Mr. GOHMERT. And I was just at the desk, Mr. Speaker, so parliamentary inquiry: If you could direct me to that place on the desk where the 200 pages are, it would be very helpful.

The SPEAKER pro tempore. The Clerk has the official papers. Additional copies are in the lobby and Members have been carrying them around all day.

Mr. GOHMERT. Parliamentary inquiry. Does the Speaker know where a copy, as the rule requires, is at the desk so that we can come up and see it at the desk as a requirement of the rules?

The SPEAKER pro tempore. The Clerk has custody of the official papers.

Mr. GOHMERT. I take that as a ''no.''

The SPEAKER pro tempore. The gentleman from Michigan has 4 minutes remaining, and the gentleman from California has the right to close.

Mr. CAMP. We will reserve our time.

Mr. WAXMAN. We are ready to close, so use your time. Use it or lose it.

Mr. CAMP. At this time, Mr. Speaker, I yield the customary 1 minute to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Let me thank my colleague for yielding, and thank him and our ranking members for the job they have done putting our substitute together.

Ladies and gentlemen, before I came here, I ran a small business. While I was running my small business, it became pretty clear to me that government was growing in my view out of control. More regulations, more taxes, more compliance costs, both for my suppliers, for my customers, and for my own little small business. It seemed to me that government was choking the goose that was laying the golden egg.

You know, we were all lucky enough to be raised in America, most of us born in America, the greatest country in the world. And it is a great country because Americans have had the freedom, the freedom to succeed, the freedom of opportunity. But I think all of us can understand that the bigger government gets, the more that it takes from the American people, the more money that individuals have to spend to comply with all of these regulations, is less money that is left in American families' pockets, small business's pockets, and as a result the opportunities, the opportunities available for our citizens get diminished.

We live in a great country. But it can only be great if we are willing to allow the freedom that Americans have had to succeed to remain. That freedom has been dimming. The bright lights of freedom have been dimming for decades because government continues to grow. One only has to look at what has happened this year to wonder why we are here tonight doing this. We all know we have had a difficult economic shock in our country over the last year.

So we see a stimulus bill that came to this floor with a promise that we were going to create jobs, jobs, jobs. And unemployment wasn't going to exceed 8 percent. Now we have unemployment rates at 10.2 percent and over 3 million Americans have lost their jobs. So all of a sudden we have a budget on the floor, a trillion-and-a-half-dollar deficit this year, and trillion-dollar deficits on average for as far as the eye can see. And I don't think there is a Member on either side of the aisle who doesn't realize that this is unsustainable, that this will wreak havoc on our country and wreak havoc on the future for our kids and our grandkids.

If there is one obligation that we have, it is to ensure that the American dream that is available to all of us is available for our kids and our grandkids. And trillion-dollar deficits for as far as the eye can see are not sustainable and will ruin their future.

But no, it wasn't enough. All of a sudden we have to have this national energy tax on the floor in June. It is called cap-and-trade because no one in America really knows what that means, but it is a giant energy tax. And it would tax anybody who drives a car, anybody who works at a place that uses electricity. Anyone who would have the audacity to flip on a light switch is going to pay a higher tax.

□ 2130

Not only are we going to pay higher taxes and have less energy and higher energy costs in America, it will ship millions of American jobs overseas at a time when Americans are asking, Where are the jobs? And the policies that have been coming down the pike all year have done nothing more than diminish the possibility that we will be creating the jobs that Americans so desperately want. That still wasn't enough. Now we are going to bring this 2,000-page bill to the floor of the House. It's going to cost over $1.3 trillion and will kill millions more American jobs.

The American people want us to focus on getting our economy moving again because they are looking for work. They want to make sure that those who have their job can keep it. What has happened here all year is we're moving policies that are going to destroy the ability of the private sector to create those jobs. But I don't think there is anything that will diminish the job prospect in America more, of all the things that have happened this year, than this health care bill.

Now, you just think about this bill that we have in front of us. It is going to raise taxes. It is going to raise insurance premiums for those who have insurance. It's full of mandates. And as if that's not enough, we are going to cut Medicare.

Now, the President said that if you like the health insurance you have, you can keep it. And I know the President was sincere in that, but that is not what this bill represents and there's not a Member in this Chamber that doesn't understand that. Because if you're a Medicare Advantage enrollee, like 27,000 of my constituents, the Congressional Budget Office says that 80 percent of them are going to lose their Medicare Advantage.

If you look at this bill and you look at the employer mandate in this bill, you will find out that if employers don't provide health insurance, there is a tax. And for many employers, the tax will be cheaper than the actual cost of health insurance. A lot of employers in America are going to look up and say, Listen, I'd rather pay the tax, and my employees are going to have to go fend for themselves and end up in the government plan.

But it doesn't stop there. This bill also requires that every employer plan that is offered today has to be approved once again by the Department of Labor and the health choices czar; big compliance cost there. Some employers are going to say, Listen, this isn't worth it. Because it's not just getting the plan reapproved again. It has to go through the health choices czar so that the health choices czar can determine whether your plan is adequate according to some Federal bureaucrat. And so a lot of employers, they're just going to get out of it. They're not going to do it. And what is going to happen to those employees who like the coverage they have today? They are going to end up in the government plan.

But no, no, it doesn't stop there. We have an individual mandate in this bill in front of us that says every American is going to buy health insurance whether you want it or not. And if you don't want it, you're going to pay a tax. And if you don't pay the tax—listen to this. If you don't pay the tax, you're going to be subject to a fine of up to $250,000 and imprisonment up to 5 years. Now, this is the most unconstitutional thing I've ever seen in my life. The idea that we can tell Americans, force Americans by some law that they have to buy health insurance or we're going to fine you and send you to jail.

But there has been all this focus on the employer mandate and on the individual mandate, on the government option, but let me tell you where there hasn't been much attention, and that is the giant bureaucracy that is being built here in Washington in the Federal Government to take control of Americans' health care system and force you out of the insurance you have and into some government-run plan.

I know most of my colleagues, they might think this is hyperbole or it might sound political. Let me tell you, it isn't. Well, just listen to this. Most of my colleagues on the left have been down here today. They are for this because it does in fact set up this big infrastructure for the government to eventually take control of all of our health care and just go to a single-payer system.

Now, it starts with the exchange that's in this bill. Once it takes effect, the health exchange, you can't buy private insurance on your own. You can't go out and buy insurance. You have to go to the exchange, and the exchange will decide for you which plans are offered to you. So, if you change your job or you don't like what you have, guess what? You get to go to the government's health exchange to get your insurance.

But it's just not the government option that I'm talking about. When you look at this infrastructure that's there, it is going to require tens of thousands

of new Federal employees. The American people want two things from health care reform: They want lower cost and they want more choices. I think the underlying bill here tonight does exactly the opposite. It raises the cost of health insurance and creates this new megabureaucracy to make health care decisions that should be left to doctors and their patients.

So let's talk about this bureaucracy for a moment. If you go to page 131, section 241 provides for an unelected ''Health Choices Commissioner'' who would run a ''Health Choices Administration,'' an independent agency of the executive branch.

Now, here are some of the examples of the powers of this new health choice commissioner—let's just call him the health czar. On page 167 through 172, in section 303, the health czar will decide which treatment patients could receive and at what cost. Or you can go to page 132, section 242, the health choices czar would decide which private plans would be allowed to participate in the exchange.

Then you go to page 127, section 234. This new health czar will regulate all insurance plans both in and out of the exchange.

Then you go to page 162 to 165, section 302, the health choices czar will determine which employers are going to be allowed to participate in the exchange.

Then you go to page 174 to 178, section 304(b), the health choices czar will decide which physicians and hospitals get to participate in the government-run plan.

Then you go to page 197 to 202, section 308, the health choices czar will determine which States are allowed to operate their own exchange and to terminate any previously approved State exchange at any time.

Then you go to page 170 and 171, section 303(d), the health choices czar can override State laws regarding covered health benefits. It's in the bill. Go read it.

Page 133, section 242(a)(2). This person will determine how trillions of taxpayer and employer dollars would be spent within the exchange.

And page 133, section 242, ''conduct random compliant audits.'' The person still has more powers here.

Page 183, section 305, automatically enroll Americans into the exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan. Now, this is referred to as ''random assignment.''

This commissioner is charged with establishing ''waiting lists'' and defining such terms as ''dependent,'' ''service area,'' ''premium rating area,'' ''employee,'' ''part-time employee,'' and ''full-time employee.'' Let's all be honest, this is the czar to end all czars.

But it doesn't stop there. When you look at this expanding bureaucracy created in the Federal Government, on page 1322, section 2401, it creates a new Center for Quality Improvement to prioritize areas for identification, development, evaluation, and implementation of best practices for quality improvement of best practices for the delivery of health care services. We've already got Centers for Quality Improvement. We've got doctors, nurses, surgeons, hospitals, laboratories, rehab facilities. But no, no, we're going to have more bureaucracy than that. We're not even close to the end of this bureaucracy.

Page 1183, section 1904 provides for $750 million in Federal funding for a new entitlement program to offer ''knowledge of realistic expectations of age-appropriate child behaviors'' and ''skills to interact with their child.'' So not only is the Federal Government going to legislate what's good for medical practices, now we're going to put $750 million into a program to help legislate how parents should parent.

Page 1198, section 1907, we establish a Center for Medicare and Medicaid innovation within the Centers for Medicare and Medicaid Services to legislate innovation as part of a bill that cuts, I think, the most innovative Medicare program we have, that's Medicare Advantage. But we still have more.

Page 25, section 101 authorizes the Secretary of Health and Human Services to reduce benefits, increase premiums, and establish waiting lists to make up for funding in the shortfalls of high-risk pools. That's right there in the bill, ''establish waiting lists.''

Pages 734, 738, and 1162, sections 1401 and 1802 create the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission and the Comparative Effectiveness Research Trust Fund. These are bureaucracies that will decide which treatments are most effective. But the bill does not provide any protection to doctors and patients that they all get to decide what's in their own best interest.

Then we get into a lot more duplicative Federal programs. Page 1432, section 2531 provides for incentive payments to States that enact new medical liability laws, but only if such laws do ''not limit attorneys' fees or impose caps on damages.'' So we're telling States to solve the problems, but also telling them not to use the tools that work most effectively in the States that are using them.

Page 1624, section 2589 creates a new Personal Care Attendant Workforce Advisory Panel. Let me say that again, a Personal Care Attendant Workforce Advisory Panel made up in part by personal care workers, including their union representatives, to study working conditions and salaries of these workers. What does this have to do with lowering health care costs?

Page 1968, section 3103 establishes a ''Committee for the Establishment of the Native American Health and Wellness Foundation.'' So we're going to set up a committee whose job it is is to set up a foundation, and we're going to take half a million dollars of Americans' money to do this.

Page 1330, section 2402 creates a new Assistant Secretary for Health Information. I guess this is another job saved or created.

Page 1391, section 2524 creates a ''No Child Left Unimmunized Against Influenza'' demonstration grant program to test the feasibility of using the Nation's elementary schools and secondary schools as influenza vaccination centers. Aren't we doing this already?

Page 1253, section 2231 creates a new Public Health Workforce Corps for the purpose of ''ensuring an adequate supply of health professionals.'' The bill also creates a ''Public Health Workforce Scholarship Program'' and a ''Public Health Workforce Loan Forgiveness Program.'' All of this duplicates the existing National Health Services Corps.

Page 1478, section 2552, the bill creates an Emergency Care Coordination Center in the Office of the Assistant Secretary for Preparedness and Response charged with working in coordination with the Federal Interagency Committee on Emergency Medical Services. And the Emergency Care Coordinator Center seeks out the advice of a Council of Emergency Care.

We're not finished yet. How about this one? Page 1515, section 2572(b) imposes a labeling requirement on all vending machines nationwide. In addition to that, we require all restaurants with more than 20 locations to post the calorie count exactly next to—and we spell this out in the law—right next to the menu, whether it's the drive-in menu, the menu on the board, the one they hand out to you. Oh, yeah. We're going to require every restaurant with more than 20 locations to do this. Oh, but that's not enough.

□ 2145

Page 872, section 1433 requires the director of food services at nursing facilities that participate in Medicare or Medicaid to hold ''military, academic, or other qualifications'' as determined by Federal bureaucrats. So now we are going to legislate the work requirements in the background of all this off.

But I think this is the best part of the bureaucracy: on page 122, section 233(a)(3) of this 2,032-page bill, it requires the commissioner to ''issue guidance on best practices of plain language writing.'' Oh, yes, it's right here in the bill. Go look at it.

Ladies and gentlemen, we know what's going on here. There are problems in our current health care system that we all want to address. I heard all the criticisms of our bill and the fact that it doesn't do everything that everybody wants it to do.

But do you know what it does do?

It lowers the cost of health insurance, and it solves the problem of those with preexisting conditions, and it begins to insure more Americans. That's what the American people want, a step-by-step approach to making the best health care system in the world better.

We can do that. What we don't need to do is to create this giant bureaucracy, spend all of this tax money, and imprison our children's future by passing this 2,000-page bill.

So, I think we do have a better solution, a commonsense solution that Americans will support.

So, tonight, here we are. We have a choice. We can pass the 2,000-page bill. We can raise taxes. We can cut Medicare. We can impose all of these mandates on employers that are going to drive employment down and unemployment up, or we can take some commonsense approach.

As I said during my remarks, our job is to do our best to make sure that our kids and grandkids have a better chance of the American Dream than we did. I understand that we've got some tough choices to make, but that's what the American people sent us here to do is to make those tough choices. I'm not going to put my kids further in debt. I'm not going to dim the lights of freedom for my kids and theirs nor for anyone's in this country if I can avoid it.

So we have a choice. We can do what's right for the future, or we can continue down this path toward bigger and bigger government. I came here to fight for freedom. I came here to renew the American Dream for our kids and our grandkids.

So I would ask my colleagues to think about that choice. Vote for the Republican alternative, and whatever you do, please vote ''no'' for the underlying bill.

Mr. WAXMAN. Mr. Speaker, to close the debate on the Democratic side, I yield the balance of my time to the dean of the House, to the lead author of the underlying bill and to a man who has fought longer for national health insurance than anyone in this institution. I yield the balance of my time to Representative JOHN DINGELL from the State of Michigan.

The SPEAKER pro tempore. The gentleman from Michigan is recognized for 5 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Speaker, I am here tonight to urge my colleagues to vote against the Republican substitute and for the bill reported by three committees after long and hard work.

I want to tell the House—all Members—how proud I am of the discussion that has taken place today. I want to commend the three committees and their chairmen, including my good friend, the chairman of our committee, Mr. WAXMAN, for the work they have done.

You, Madam Speaker and the leadership, we thank you for the extraordinary leadership which you have given us in bringing this to the point where we are tonight. Thank you.

I won't begin by spending much time on the bill offered by my Republican colleagues. It is really no substitute for H.R. 3962. According to The New York Times—and I think this sufficiently disposes of the matter—the Republican amendment does ''almost nothing to reduce the scandalously high number of Americans who have no insurance, and it makes only a token stab at slowing the relentlessly rising costs of medical care.''

Interestingly enough, under the Republican amendment, individuals would pay up to $2,821 more, and families would pay up to $8,188 more under the Republican plan when compared with H.R. 3962. It's not in the public interest that we should do that.

Having said that, this is historic legislation. It addresses two of the most terrifying problems we have in this country:

The first is what was the problem when my dad introduced the first legislation in 1943, that there are now some 47 million Americans without health care. This will give many of them adequate health care and a decent choice of what they will have before them at the best possible price through an exchange, which will make it possible for them to choose without having to worry about understanding the language of Philadelphia lawyers and reading fine print that can only be read with a magnifying glass.

The bill does something more. It takes care of an economic problem that will be visited on us in 2080 when the costs of health care will equal the gross domestic product of the United States. That will bring us to a fine economic mess if we permit that to happen. Health care and GDP costs will be equal.

Now, the bill carries out the President's suggestions: deficit neutral. It provides coverage for 96 percent of Americans. It offers everyone, regardless of income, age, health status, the peace of mind that comes from knowing that they will have real access to affordable health insurance when they need it.

It does away with preexisting conditions, which the bill offered by my friends in the minority does not; and it sees to it that, when you go to bed at night, you're going to wake up knowing in the morning that you're going to have health insurance. It can't have been dropped by your employer, and it can't have been canceled by your insurance.

There is a practice, on which we just had hearings, that is engaged in by the insurance companies. It is called ''rescission.'' They can cancel your insurance policy by the simple device of rescinding your policy because they say you have some preexisting conditions, and they can do it while you're on the gurney, being rolled into the operating amphitheater.

The bill is going to give choice and honest competition. It is going to bring security to our seniors, and it is going to reduce out-of-control health care costs that are crushing American business.

It costs $4 an hour less to make a car in Canada than it does in Michigan. Why? Because the Canadians have a program of national health insurance which ensures that the manufacturer can compete and out-compete Americans because he doesn't carry that economic burden.

Today, this may be a tough vote, but it was in 1935 when we passed Social Security. I hear my colleagues tell us that the economy, jobs and financial system overhaul, are desperately needed. True. But that was the case in '35 when we passed the Social Security Act.

Now I hear my Republican colleagues tell us this is going to stand between—or permit a government bureaucrat to stand between the insured and the doctor and each other. In point of fact, it is going to permit the government to stand between the insurance bureaucrat and the insured, and it is going to stand between him and the doctor so that the doctor can provide the care he wants.

The problems this historic legislation aims to address are real and worsening for American citizens, business, and governments. When my Dad introduced this legislation sixty some years ago, it was a simple humanitarian problem. Today it is one of impending economic disaster to America.

H.R. 3962 meets the goals President Obama outlined for us earlier this year: it is deficit neutral; it provides coverage for 96 percent of Americans; and it offers everyone, regardless of income, age or health status, the peace of mind that comes from knowing they will have real access to quality, affordable health insurance when they need it; that preexisting conditions will not bar them from insurance; that loss of job or dropping of coverage by employer will not deny insurance.

This bill will stop discrimination against people with pre-existing conditions, and it will stop rescission—the practice in which an insurer searches for problems with patients' policies while they are waiting on a gurney for emergency care.

Additionally, this bill will ensure choice and honest competition; bring security to our seniors; and will reduce the out-of-control health care costs that are crushing American businesses.

Now is the time for health care reform. We can't afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.

Mr. Speaker, I have heard from a number of my colleagues, and I appreciate the fact the vote before us today is a tough vote.

I understand there are numerous competing issues confronting the American people—the economy, jobs, financial system overhaul. That was so in 1935 when we enacted Social Security over just about the same objections.

However, we know that no issue has caused the American people to suffer longer than the issue of inaccessible health care.

History and the American people will ask what we did here this day when presented with a real opportunity to ease the strain of rising health care costs and provide quality, affordable health coverage for all.

Mr. Speaker, the vote for me today will be on behalf of American families who are forced to decide whether they will pay the mortgage or their health insurance premium.

My vote today is for American business—big and small. They are confronted with the real burden of providing quality health care for their workers or fall victim to their foreign competitors.

My vote today is for the federal government, and state and local governments throughout the country which are being stretched to make room for larger and larger health bills.

Mr. Speaker, my vote today is also personal.

It is a vote to fulfill the legacy left by a little, skinny Polack with a broken nose and a mustache who served as a proud Member of this distinguished body.

My father, John D. Dingell, Sr., was a part of the original New Dealers—a brand of big thinking Democrats—who believed that health care is a right, not a privilege and government had a responsibility to protect it people; provide for their basic rights; and ensure opportunity for all.

So, it is in that tradition that I urge my colleagues to act today to pass this bill.

Join with the AMA, the AARP, the Consumers Union, the American Cancer Society, the different medical specialist groups, the Nurses and others who support this bill.

Mr. Speaker, we have an opportunity today, to do something meaningful for the American people and for American business.

We can take advantage of this opportunity or we can shirk our responsibilites and allow the calamitous situation that faces our people to contine to grow out of hand, overwhelm the federal budget, force more and more families into bankruptcy, and shift more jobs overseas.

Reform is neither easy nor cheap, but the cost of inaction is far greater—in terms of lost lives, quality of life and dollars. If we don't reduce costs we face certain economic disaster.

So, today, we must overcome the naysayers, the loyal opposition, the lies about our plan, the fear that causes us to think the status quo is the safe thing to do.

We must overcome all of these things and we must act boldly, with conviction, and deliberately—not because of our own righteousness—but because there is no other acceptable alternative.

I urge my colleagues to vote ''yes'' on H.R. 3962 and give the American people the relief they so desperately need.

Ms. RICHARDSON. Mr. Speaker, I rise today to oppose the Boehner amendment and in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

President Theodore Roosevelt proposed national health insurance in 1908. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens.

Today, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won't bankrupt their families.

The health care system we have now is not working for middle and working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured.

There are 54 million Americans who are uninsured who need us to reform this broken system. One in five Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, the Affordable Health Care for Americans Act is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It eliminates co-pays and deductibles for preventive care while putting an annual cap on out-of-pocket expenses for American families.

Now, we need to stop playing politics and focus on actually improving people's lives. H.R. 3962 will reform the health care system so that it provides quality, affordable coverage that cannot be taken away. It eliminates discrimination based on gender and preexisting conditions. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

The hour is late, and the need is great. I urge my colleagues to vote ''no'' on the Boehner Amendment and ''yes'' on H.R. 3962.

Mr. GALLEGLY. Mr. Speaker, I rise in support of the amendment offered by Mr. BOEHNER. I have long supported changes to current health care system which reduce health care costs through increased efficiency and provide affordable insurance for people with preexisting conditions. But, at the same time, any changes to our current system should ensure doctors and patients are allowed to make health care decisions—not government bureaucrats.

Therefore, I support real health insurance reform and support the version offered by the Minority Leader, which would:

Lower health care premiums for working families,

Allow small businesses to join together in order to buy reasonably priced health insurance,

Reduce medical costs by limiting frivolous medical malpractice lawsuits,

Prevent insurers from unjustly cancelling health insurance policies, and Establish universal access programs that provide affordable insurance for people with preexisting conditions.

Mr. Speaker, we should not consider changes of this magnitude without a complete report from the nonpartisan Congressional Budget Office, CBO. The preliminary estimate from the CBO puts the cost of H.R. 3962 at more than $1.05 trillion, but many independent experts believe this bill will actually increase Federal expenditures by more than $1.3 trillion.

In addition, this bill would impose $730 billion in new taxes and mandates on individuals and small businesses. Most economists, including CBO experts, have concluded that these requirements could increase unemployment by discouraging businesses from hiring low-wage workers. It could also lead to wage stagnation as payroll is diverted to comply with new Federal mandates on health care coverage.

I am also concerned about the impact of this proposal on Medicare beneficiaries. H.R. 3962 would cut $400 billion from Medicare over 10 years, including a $170 billion reduction to Medicare Advantage plans, which provides insurance coverage for many seniors.

Finally, H.R. 3962 does not address the problem of frivolous malpractice lawsuits in a meaningful way. These suits lead to the practice of expensive, defensive medicine and raise the health care expenses of all patients.

I urge my colleagues to reject H.R. 3962 and support the amendment offered by Mr. BOEHNER.

Mr. SAM JOHNSON of Texas. Mr. Speaker, today, I want to add my support for the Republican substitute amendment, the Commonsense Health Care Reform and Affordability Act. This amendment is a patient centered solution to healthcare reform that our country can afford and that members on both sides of the aisle can support. It also addresses the number one concern on the mind of all Americans in this country: the high cost of health care.

The Congressional Budget Office has estimated that this Republican substitute amendment would reduce health insurance premiums by up to 8 percent for those families who currently do not have access to employer-provided coverage. My constituents have told me over and over again that the cost of healthcare is too high. They need healthcare that is more affordable, accessible and available and the Commonsense Health Care Reform and Affordability Act provides just that.

Included in the Republican substitute amendment is my bill, H.R. 2607, the Small Business Health Fairness Act. This legislation allows small businesses to band together to purchase health insurance so they can enjoy the same bargaining power large corporations and labor unions have at the purchasing table. In all parts of our economy we know that buying in bulk reduces the price tag, and healthcare is no different. Government-forced healthcare is not the way to solve our health care problem. We can and have to do better.

With almost 60 percent of the uninsured population tied to a small business, this provision in the Commonsense Health Care Reform and Affordability Act, helps bring access to affordable healthcare to those that currently don't have it. Clearly, there are better ways to make healthcare more accessible for American families—and this Republican substitute is it.

Real healthcare reform should protect doctors and hospitals from frivolous lawsuits, so they can stop practicing defensive medicine and instead focus on practicing patient-focused care. This amendment extends medical liability reform that has been successful in several States to the rest of the Nation, saving lives and saving money.

Another provision in the Republican substitute amendment I am proud to support is the State Innovations Program. The amendment provides incentives to States who adopt reforms that reduce the cost of health insurance and expand coverage to the citizens of their States.

This provision allows States the freedom to solve their health problems on their own. Speaker PELOSI's health-care bill focuses on the Federal Government trying to fix what is broken with our health care. But in my great State of Texas, I believe those that are best

equipped to solve our healthcare problems are Texans. It is time for real reform that works and not the same old answers of more money and more government.

Finally, this amendment protects American innovation while ensuring patients will have more cutting edge treatment options in the area called ''follow on biologics.'' The Commonsense Health Care Reform and Affordability Act contains a provision that will create a pathway for new, life saving products while maintaining the proper incentives for companies to research and strive to discover them. Most importantly, this provision will ensure that many of the jobs created in this industry will stay in the United States.

The Commonsense Health Care Reform and Affordability Act is exactly the solution the American public has asked Congress to pass. It saves money, lowers the cost of health care, protects the patient-doctor relationship and keeps the government out of personal healthcare decisions. I ask my colleagues to join me in supporting this amendment today.

Mr. CAMP. Mr. Speaker, I yield back the balance of my time.

Mr. WAXMAN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the amendment offered by the gentleman from Ohio (Mr. BOEHNER).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. CAMP. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, further proceedings on this question will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, proceedings will now resume on the amendments printed in parts C and D of House Report 111–330 on which further proceedings were postponed, in the following order:

Amendment printed in part C by Mr. STUPAK of Michigan.

Amendment printed in part D by Mr. BOEHNER of Ohio.

The Chair will reduce to 5 minutes the time for any electronic vote after the first vote in this series.

AMENDMENT OFFERED BY MR. STUPAK

The SPEAKER pro tempore. The unfinished business is the vote on the amendment offered by the gentleman from Michigan (Mr. STUPAK) on which the yeas and nays were ordered.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

The SPEAKER pro tempore. The question is on the amendment.

The vote was taken by electronic device, and there were—yeas 240, nays 194, answered ''present'' 1, not voting 0, as follows:

[Roll No. 884]

YEAS—240

Aderholt
Akin
Alexander
Altmire
Austria
Baca
Bachmann
Bachus
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cardoza
Carney
Carter
Cassidy
Castle
Chaffetz
Chandler
Childers
Coble
Coffman (CO)
Cole
Conaway
Cooper
Costa
Costello
Crenshaw
Cuellar
Culberson
Dahlkemper
Davis (AL)
Davis (KY)
Davis (TN)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Ehlers
Ellsworth
Emerson
Etheridge
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Griffith
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hill
Hoekstra
Holden
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
Kanjorski
Kaptur
Kildee
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Langevin
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lipinski
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Lynch
Mack
Manzullo
Marchant
Marshall
Matheson
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McIntyre
McKeon
McMorris Rodgers
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Murphy, Tim
Murtha
Myrick
Neal (MA)
Neugebauer
Nunes
Oberstar
Obey
Olson
Ortiz
Paul
Paulsen
Pence
Perriello
Peterson
Petri
Pitts
Platts
Poe (TX)
Pomeroy
Posey
Price (GA)
Putnam
Radanovich
Rahall
Rehberg
Reichert
Reyes
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Royce
Ryan (OH)
Ryan (WI)
Salazar
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shimkus
Shuler
Shuster
Simpson
Skelton
Smith (NE)
Smith (NJ)
Smith (TX)
Snyder
Souder
Space
Spratt
Stearns
Stupak
Sullivan
Tanner
Taylor
Teague
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NAYS—194

Abercrombie
Ackerman
Adler (NJ)
Andrews
Arcuri
Baird
Baldwin
Bean
Becerra
Berkley
Berman
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Capps
Capuano
Carnahan
Carson (IN)
Castor (FL)
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Courtney
Crowley
Cummings
Davis (CA)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Edwards (MD)
Edwards (TX)
Ellison
Engel
Eshoo
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Grayson
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kennedy
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Maffei
Maloney
Markey (CO)
Markey (MA)
Massa
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McMahon
McNerney
Meek (FL)
Meeks (NY)
Miller (NC)
Miller, George
Minnick
Mitchell
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Nadler (NY)
Napolitano
Nye
Olver
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Peters
Pingree (ME)
Polis (CO)
Price (NC)
Quigley
Rangel
Richardson
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Sires
Slaughter
Smith (WA)
Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Woolsey
Wu
Yarmuth

ANSWERED ''PRESENT''—1

Shadegg

□ 2220

Mr. COHEN and Ms. JACKSON-LEE of Texas changed their vote from ''yea'' to ''nay.''

Messrs. SPRATT and LEWIS of California changed their vote from ''nay'' to ''yea.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AMENDMENT OFFERED BY MR. BOEHNER

The SPEAKER pro tempore. The unfinished business is the vote on the amendment offered by the gentleman from Ohio (Mr. BOEHNER) on which the yeas and nays were ordered.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

The SPEAKER pro tempore. The question is on the amendment.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 176, noes 258, not voting 0, as follows:

[Roll No. 885]

YEAS—176

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)

Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Carter
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NAYS—258

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Taylor
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

□ 2228

So the amendment was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. CANTOR. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CANTOR. Yes, Mr. Speaker, in its current form.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the motion is considered as read.

The text of the motion is as follows:

Mr. Cantor moves to recommit the bill, H.R. 3962, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendments:

Page 1209, after line 15, insert the following new title (and conform the table of contents of division B, and the table of divisions, titles and subtitles in section 1(b), accordingly):

TITLE X—SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND

SEC. 1911. FINDINGS.

Congress finds the following:

(1) When analyzing the Medicare cuts in division B, The Office of the Actuary (OACT) of the Centers for Medicare & Medicaid Services noted that ''The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and changes in providers' willingness to treat patients with low-reimbursement health coverage.''.

(2) When analyzing the Medicare cuts contained in division B, OACT predicts that, ''Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the provider's costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries).''.

(3) The Medicare Payment Advisory Commission (MedPAC) found that 28 percent of seniors currently have difficulty finding a new physician to treat them.

(4) Medicare geographic payment inequities are well documented and have been extensively studied.

(5) The Congressional Budget Office states that per capita health care spending varies widely across the United States.

(6) Low-cost, high-quality States are setting the national standard for Medicare yet they are penalized by the current Medicare reimbursement formula.

(7) Geographic payment inequities must be resolved for health care reform to be successful and for Medicare to achieve long-term sustainability.

(8) Rural counties face unique challenges in delivering health care.

(9) MedPAC finds that every senior currently has the ability to enroll in a Medicare Advantage plan instead of the traditional government program. The Commission predicts that because of Medicare cuts contained in division B, 1 in 5 seniors will no longer have this choice and be forced to receive their Medicare benefits from the traditional program.

(10) OACT predicts that the Medicare cuts contained in division B will reduce seniors' projected enrollment in Medicare Advantage plans by 64 percent.

(11) MedPAC estimates that, on average, Medicare physician reimbursements are 20 percent lower than the reimbursements physicians receive from private health plans.

(12) MedPAC predicts that, on average, Medicare hospital reimbursements will be 6.9 percent below the cost of providing care in 2009.

SEC. 1912. SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish under this title a Seniors Protection and Medicare Regional Payment Equity Fund (in this section referred to as the ''Fund'') which shall be available to the Secretary to provide for improvements (described in subsection (b)(1)) under the Medicare program under title XVIII of the Social Security Act.

(b) IMPROVEMENTS MADE BY FUND.—

(1) IN GENERAL.—The improvements described in this paragraph are the following:

(A) CORRECTING PAYMENT INEQUITIES.—In order to correct inequities in Medicare payment policies that punish high-quality, low-cost counties (as defined in paragraph (2)) and to promote high quality, cost effective patient care, by providing additional funding to Medicare providers located in such counties.

(B) PRESERVING SENIORS' CHOICE.—In order to preserve seniors' ability to choose the Medicare health benefits that best meet their needs, by providing additional funding

to ensure that every Medicare beneficiary continues to have access to at least 1 Medicare Advantage plan under part C of the Medicare program.

(C) ACCESS TO MEDICALLY NECESSARY CARE AND TREATMENT.—By providing such additional funding as may be necessary to ensure access by Medicare beneficiaries to medically necessary care and treatment, including care and treatment furnished by physicians, hospitals, and other health care providers under the Medicare program, without wait lines or coverage determinations based solely on the basis of cost.

(2) HIGH QUALITY, LOW-COST COUNTY DEFINED.—In this subsection, the term ''high quality, low-cost county'' means a county (or equivalent area) in which, as determined by the Secretary—

(A) the quality of care exceeds the national average; and

(B) the per beneficiary fee-for-service Medicare costs are substantially lower than the national average.

(c) FUNDING.—

(1) IN GENERAL.—There shall be available to the Fund—

(A) $13,500,000,000 for expenditures from the Fund during 5-year period beginning with 2010; and

(B) $40,500,000,000 for expenditures from the Fund during the 5-year period beginning with 2015.

Such amounts reflect savings in Federal expenditures and increases in Federal revenues estimated to result from the provisions of division E.

(2) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

Add at the end the following (and conform the table of divisions, titles, and subtitles in section 1(b) accordingly):

DIVISION E—ENACTING REAL MEDICAL LIABILITY REFORM

TABLE OF CONTENTS OF DIVISION

SEC. 4101. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 4102. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this division shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 4103. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 4104. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 4105. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the

case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 4106. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this division.

SEC. 4107. DEFINITIONS.

In this division:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 4108. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this division does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this division in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death

to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this division or otherwise applicable law (as determined under this division) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this division shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 4109. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this division preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this division. The provisions governing health care lawsuits set forth in this division supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this division; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this division (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This division shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this division or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this division shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this division, notwithstanding section 4102(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 4110. APPLICABILITY; EFFECTIVE DATE.

This division shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia is recognized for 5 minutes in support of the motion.

□ 2230

Mr. CANTOR. Mr. Speaker, any physician in America will tell you that the simplest way to reduce health care costs is to enact real medical liability reform. The fear of being sued by opportunistic trial lawyers is pervasive in the practice of medicine. Our system wastes billions on defensive medicine that should be going to patient care. That's why real medical liability reform is needed. In fact, CBO estimates that as much as $54 billion can be saved by the Federal Government alone. It is totally unacceptable that this money is being spent in the courtroom instead of the operating room.

At the same time, the majority has promised the American people that their health care bill will lower costs, yet the bill before us today, Mr. Speaker, contains no medical liability reforms. And why not? The truth comes from one of the Democrats' own, no less than former DNC Chair and physician Howard Dean, who said last August, The reason that tort reform is not in the bill is because the people that wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth.

Mr. Speaker, the Republican motion to recommit adds real meaningful medical liability and reform and uses its $54 billion in savings to create a fund that will protect seniors, especially those in rural areas, from the steep cuts to Medicare in the Democrats' reform package. It gives Members the chance to prioritize the health of our Nation's seniors instead of lining the bank accounts of trial lawyers. It's time to get trial lawyers out of the clinics and the operating rooms and leave patient care to the people trained to handle it best—our doctors.

Mr. Speaker, to talk about this further, I now yield to the gentlewoman from Florida, Congresswoman BROWN-WAITE.

Ms. GINNY BROWN-WAITE of Florida. Betty, a constituent of mine, recently told me that if it weren't for Medicare Advantage, she would be dead. You see, Medicare Advantage covers catastrophic costs traditional Medicare does not. The bill before us today seeks to eliminate that coverage for millions of seniors, but you have a chance to make it right here, ladies and gentlemen.

The choice on the motion is simple. You can put your seniors first or your trial lawyer contributors. A Member can vote to open up the coffers of the U.S. Treasury to trial lawyers or restore some of the cuts our seniors will suffer under the Pelosi bill and ObamaCare. Remember, this bill creates 111 new bureaucracies and entitlements, but the only one it cuts, ladies and gentlemen, the only one it cuts is Medicare. It's always been my position that any money cut from Medicare should be used to save Medicare, not to bail out the trial attorneys.

Democrats have denied seniors the protection they promised. They cut Medicare to create new benefits for the young, healthy, and the wealthy. We know where the Democrat leadership stands on this issue. The Speaker put her trial lawyer cash cows ahead of our seniors. AARP put their profits ahead of our seniors.

With this motion, you have a chance to restore some of our cuts. No excuses about this amendment killing the bill can be made. No word games can get you out of this. This has to be a vote for the seniors of America. Please remember your constituents will be watching.

Mr. CANTOR. Mr. Speaker, I now yield to the gentleman from Washington (Mr. REICHERT).

Mr. REICHERT. Thank you.

This motion was and will protect seniors from drastic cuts to Medicare and stop expensive lawsuits that increase the costs of health care for every American. We've heard, If you like it, you can keep it, but the bill before us is a direct assault on America's seniors, cutting $500 billion from Medicare.

Under this bill, one out of every five seniors will lose the Medicare health plan they chose. Because of regional payment disparities in many parts of this country, Medicare Advantage plans are the only way seniors can receive needed care. It's the only way that seniors can choose their doctors, and it's the only way that seniors can choose the preventive treatment they need.

This motion is about choice. It's about living in a free country. It's about having freedom. Mr. Speaker, this commonsense motion will protect seniors' health care, lower health care costs, and preserve freedom.

Mr. HOYER. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Maryland is recognized for 5 minutes.

Mr. HOYER. Mr. Speaker, I yield to the gentleman from Iowa (Mr. BRALEY).

Mr. BRALEY of Iowa. Mr. Speaker, during this entire health care debate, we've heard a lot from our friends on the other side of the aisle about something called medical liability reform, but all day as they've been talking about this point, you have not heard one word about patient safety. If you want to talk about real meaningful health care reform, it's important to talk about the most critical aspect of true, meaningful health care reform—standing up for patients. Who will speak for the patients?

Mr. Speaker, we know who will speak for the patients. We have the reports from the highly respected nonpartisan Institute of Medicine on patient safety. The first one is on patient safety, Achieving a New Standard for Care. The second one, Preventing Medication Errors, and To Err Is Human: Building a Safer Health System.

What did the Institute of Medicine tell us about the state of patient safety? They told us that the most significant way to reduce the costs of medical malpractice is to emphasize patient safety by reducing the number of preventable medical errors. They also told us that's the only way we're going to

bring about meaningful health care reform. They also told us that medical errors kill as many as 98,000 Americans every year; and that, if it were ranked by the Centers for Disease Controls, would be the sixth leading cause of deaths in America.

□ 2240

They also told us that every year there are 15 million incidents of medical harm in this country and that patient safety is indistinguishable from the delivery of medical care. That's why they aren't telling you about what the Institutes of Medicine reported the cost of medical errors is in this country.

They reported in their studies that every year medical errors add $17 billion to $28 billion of cost, most of it in additional medical care that we end up paying for as consumers of health care. When you multiply that over the 10 years of this bill, that means it's costing us $170 billion to $280 billion if we continue to ignore this problem. That's why Democrats and the Institutes of Medicine are standing up for patients, and that's why you should reject this motion to recommit.

You hear our friends talk about what happened in California in 1976 when they put a $250,000 cap on payments for quality-of-life damages. What they don't tell you is that the value of that cap today in 2009 is $64,000, and if you adjust that cap at the same rate of medical inflation, it would be worth $1.9 million. That's what's wrong.

Mr. HOYER. I thank the gentleman for his comments.

My colleagues, I ask you to reject this amendment. Our colleagues on the other side of the aisle demanded 72 hours' notice for the bill and they've gotten 4 or 5 months' notice. They gave us 72 seconds to consider this amendment.

This amendment deals with some very complicated subjects; and it provides, of course, as we are not surprised that it would, for substantial billions of dollars back to the insurance companies. That's what their objective is. And, yes, they say something about equity of distribution of money. No study.

We set up a very careful study to make sure that the people's money is distributed to the States in an equitable, fair, effective fashion. That is why we ought to reject this amendment for which we received no notice, no consideration, no discussion in the public. The Republicans have been outraged about that.

I ask our party, I ask each one of us, to reject this motion to recommit and pass this bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. CANTOR. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 187, noes 247, not voting 0, as follows:

[Roll No. 886]

AYES—187

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boren
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cardoza
Carter
Cassidy
Castle
Chaffetz
Childers
Coble
Coffman (CO)
Cole
Conaway
Costa
Crenshaw
Cuellar
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Ehlers
Ellsworth
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Griffith
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Matheson
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy (NY)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Pomeroy
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOES—247

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Capps
Capuano
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costello
Courtney
Crowley
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ellison
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Grayson
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Taylor
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

□ 2259

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. BURTON of Indiana. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on passage of the bill will be followed by a 5-minute vote on the motion to suspend the rules on House Resolution 895.

The vote was taken by electronic device, and there were—ayes 220, noes 215, not voting 0, as follows:

[Roll No. 887]

AYES—220

Abercrombie
Ackerman
Andrews
Arcuri
Baca
Baldwin

Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Cao
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Grayson
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Klein (FL)
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (MA)
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Perriello
Peters
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Sires
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOES—215

Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Austria
Bachmann
Bachus
Baird
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boucher
Boustany
Boyd
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Capito
Carter
Cassidy
Castle
Chaffetz
Chandler
Childers
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (AL)
Davis (KY)
Davis (TN)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Edwards (TX)
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Griffith
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Herseth Sandlin
Hoekstra
Holden
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kissell
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Markey (CO)
Marshall
Massa
Matheson
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
Melancon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy (NY)
Murphy, Tim
Myrick
Neugebauer
Nunes
Nye
Olson
Paul
Paulsen
Pence
Peterson
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuler
Shuster
Simpson
Skelton
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Tanner
Taylor
Teague
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER (during the vote). There are 2 minutes remaining in the vote.

□ 2316

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

HONORING VICTIMS OF FORT HOOD ATTACK

The SPEAKER pro tempore (Mr. EDWARDS of Texas). The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 895, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Missouri (Mr. SKELTON) that the House suspend the rules and agree to the resolution, H. Res. 895.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 428, nays 0, not voting 7, as follows:

[Roll No. 888]

YEAS—428

Abercrombie
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George